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SALUS POPULI SUPREMA LEX ESTO

*“The welfare of the people shall be the supreme law.”*



JOHN R. ASHCROFT  
SECRETARY OF STATE

# MISSOURI REGISTER

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**SECRETARY OF STATE**

**JOHN R. ASHCROFT**

Administrative Rules Division

James C. Kirkpatrick State Information Center

600 W. Main

Jefferson City, MO 65101

(573) 751-4015

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•

MANAGING EDITOR

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•

PUBLICATION SPECIALIST II

JACQUELINE D. WHITE

•

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ADMINISTRATIVE AIDE III

TAMMY WINKELMAN

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October 17, 2022	November 15, 2022	November 30, 2022	December 30, 2022

Documents will be accepted for filing on all regular workdays from 8:00 a.m. until 5:00 p.m. We encourage early filings to facilitate the timely publication of the *Missouri Register*. Orders of Rulemaking appearing in the *Missouri Register* will be published in the *Code of State Regulations* and become effective as listed in the chart above. Advance notice of large volume filings will facilitate their timely publication. We reserve the right to change the schedule due to special circumstances. Please check the latest publication to verify that no changes have been made in this schedule. To review the entire year's schedule, please see the website at [sos.mo.gov/adrules/pubsched](https://sos.mo.gov/adrules/pubsched).

## HOW TO CITE RULES AND RSMO

### RULES

The rules are codified in the *Code of State Regulations* in this system–

Title	CSR	Division	Chapter	Rule
3	<i>Code of</i>	10-	4	.115
Department	<i>State</i>	Agency	General area	Specific area
	<i>Regulations</i>	division	regulated	regulated

and should be cited in this manner: 3 CSR 10-4.115.

Each department of state government is assigned a title. Each agency or division in the department is assigned a division number. The agency then groups its rules into general subject matter areas called chapters and specific areas called rules. Within a rule, the first breakdown is called a section and is designated as (1). Subsection is (A) with further breakdown into paragraphs 1., subparagraphs A., parts (I), subparts (a), items I. and subitems a.

The rule is properly cited by using the full citation; for example, 3 CSR 10-4.115, NOT Rule 10-4.115.

Citations of RSMo are to the *Missouri Revised Statutes* as of the date indicated.

### ***Code and Register on the Internet***

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The *Register* address is [sos.mo.gov/adrules/moreg/moreg](http://sos.mo.gov/adrules/moreg/moreg)

These websites contain rulemakings and regulations as they appear in the *Code* and *Registers*.

**R**ules appearing under this heading are filed under the authority granted by section 536.025, RSMo. An emergency rule may be adopted by an agency if the agency finds that an immediate danger to the public health, safety, or welfare, or a compelling governmental interest requires emergency action; follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances; follows procedures which comply with the protections extended by the *Missouri* and the *United States Constitutions*; limits the scope of such rule to the circumstances creating an emergency and requiring emergency procedure, and at the time of or prior to the adoption of such rule files with the secretary of state the text of the rule together with the specific facts, reasons, and findings which support its conclusion that there is an immediate danger to the public health, safety, or welfare which can be met only through the adoption of such rule and its reasons for concluding that the procedure employed is fair to all interested persons and parties under the circumstances.

**R**ules filed as emergency rules may be effective not less than ten (10) business days after filing or at such later date as may be specified in the rule and may be terminated at any time by the state agency by filing an order with the secretary of state fixing the date of such termination, which order shall be published by the secretary of state in the *Missouri Register* as soon as practicable.

**A**ll emergency rules must state the period during which they are in effect, and in no case can they be in effect more than one hundred eighty (180) calendar days or thirty (30) legislative days, whichever period is longer. Emergency rules are not renewable, although an agency may at any time adopt an identical rule under the normal rulemaking procedures.

**Title 13—DEPARTMENT OF SOCIAL SERVICES  
Division 70—MO HealthNet Division  
Chapter 15—Hospital Program**

**EMERGENCY AMENDMENT**

**13 CSR 70-15.010 Inpatient Hospital Services Reimbursement Methodology.** The division is amending sections (1), (2), (3), (4), (5), (6), (7), (8), (9), (10), and (11) and adding sections (12), (13), (14), and (15).

**PURPOSE:** *This emergency amendment changes the inpatient reimbursement methodology, deletes or clarifies outdated terms, language, and provisions regarding inpatient hospital services reimbursement methodologies.*

**EMERGENCY STATEMENT:** *This emergency amendment replaces the existing inpatient reimbursement methodology with a new inpatient reimbursement model effective July 1, 2022. The Department of Social Services, MO HealthNet Division (MHD) finds that this emergency rule is necessary to preserve a compelling governmental interest as it allows the State Medicaid Agency to pay hospitals based on a third prior year cost report, and allows MHD to make supplemental payments to Missouri hospitals for services provided to Medicaid participants. These payments provide hospitals the ability to provide sufficient medical care to Medicaid participants. As a result, the MHD finds it necessary to preserve its compelling governmental interest in providing these payments to hospitals under the new pay-*

*ment model by July 1, 2022, which requires an early effective date. A proposed amendment, which covers the same material, will be published in an upcoming issue of the Missouri Register. The scope of this emergency amendment is limited to the circumstances creating the emergency and complies with the protections extended by the Missouri and United States Constitutions. The MHD believes this emergency amendment to be fair to all interested parties under the circumstances. This emergency amendment was filed June 14, 2022, becomes effective July 1, 2022, and expires February 23, 2023.*

**(1) General Reimbursement Principles.**

(A) For inpatient hospital services provided for an individual entitled to Medicare Part A inpatient hospital benefits and eligible for MO HealthNet, reimbursement from the MO HealthNet Program will be available only when MO HealthNet's applicable payment schedule amount exceeds the amount paid by Medicare. MO HealthNet's payment will be limited to the lower of the deductible and coinsurance amounts or the amount the MO HealthNet applicable payment schedule amount exceeds the Medicare payments. For all other MO HealthNet participants, unless otherwise limited by rule, reimbursement will be based solely on the individual participant's days of care (within benefit limitations) multiplied by the individual hospital's Title XIX *per diem* rate. *[As described in paragraph (5)(D)2. of this rule, as part of each hospital's fiscal year-end cost settlement determination, a comparison of total MO HealthNet-covered aggregate charges and total MO HealthNet payments will be made and any hospital whose aggregate MO HealthNet per diem payments exceed aggregate MO HealthNet charges will be subject to a retroactive adjustment.]*

(B) *The Title XIX reimbursement for hospitals located outside Missouri and for federally-operated hospitals in Missouri will be determined as stated in 13 CSR 70-15.190.]*

[(C)](B) The Title XIX reimbursement for hospitals, excluding those located outside Missouri *[and in-state federal hospitals]*, shall include *[per diem payments, outpatient payments, disproportionate share payments, and various MO HealthNet Add-On payments]* the payments as outlined below. Reimbursement shall be subject to availability of federal financial participation (FFP).

1. **Inpatient** *[Per]*per diem reimbursement is established in accordance with *[section (3)]* sections (4) and (5).

2. Outpatient reimbursement is *[described]* established in accordance with 13 CSR 70-15.160.

3. *[Disproportionate share payments are described in 13 CSR 70-15.220.]* Acuity Adjustment Payment (AAP) is established in accordance with Section (6).

4. *[MO HealthNet Add-Ons are described in sections (9) and (10) of this rule and 13 CSR 70-15.015 and are in addition to MO HealthNet per diem payments. These payments are subject to the federal Medicare Upper Limit test.]* Poison Control (PC) Payment is established in accordance with section (7).

5. Stop Loss Payment (SLP) is established in accordance with section (8).

6. Disproportionate Share Hospital (DSH) Payment is established in accordance with 13 CSR 70-15.220.

7. Graduate Medical Education (GME) Payment is established in accordance with section (9).

8. Upper Payment Limit (UPL) Payment is established in accordance with 13 CSR 70-15.230.

9. Children's Outlier (CO) Payment is established in accordance with section (10).

(C) The Title XIX reimbursement for hospitals located outside Missouri will be established in accordance with 13 CSR 70-15.190.

## (2) Definitions.

(A) Allowable costs. Allowable costs are those related to covered MO HealthNet services defined as allowable in 42 CFR chapter IV, part 413, except as specifically excluded or restricted in 13 CSR 70-15.010 or the MO HealthNet hospital provider manual and detailed on the *[desk-reviewed Medicare/audited Medicaid cost report]*. Penalties or incentive payments as a result of Medicare target rate calculations shall not be considered allowable costs. Implicit in any definition of allowable cost is that this cost is allowable only to the extent that it relates to patient care; is reasonable, ordinary, and necessary; and is not in excess of what a prudent and cost-conscious buyer pays for the given service or item. *[For purposes of calculating disproportionate share payments and to ensure federal financial participation (FFP), allowable uncompensated costs must meet definitions defined by the federal government.]*

(B) Bad debt. Bad debts include the costs of caring for patients who have insurance but are not covered for the particular services, procedures, or treatment rendered. Bad debts do not include the cost of caring for patients whose insurance covers the given procedures but limits coverage. In addition, bad debts do not include the cost of caring for patients whose insurance covers the procedure although the total payments to the hospital are less than the actual cost of providing care.

(C) Base year cost report. *[Desk-reviewed Medicare/Audited Medicaid cost report from the third prior calendar year.]* When a facility has more than one (1) cost report with periods ending in the *[fourth]* third prior calendar year, the cost report covering a full twelve- (12-) month period will be used. If none of the cost reports covers a full twelve (12) months, the cost report with the latest period will be used. If a hospital's base year cost report is less than or greater than a twelve- (12-) month period, the data shall be adjusted, based on the number of *[months/]* days reflected in the base year cost report to a twelve- (12-) month period. Any changes to the base year cost report after the Division issues a final decision on assessment or payments will not be included in the calculations.

(D) Case Mix Index (CMI). The hospital CMI for the AAP is determined based on the hospital's MO HealthNet inpatient claims and 3M™ All-Patient Refined Diagnosis Related Groups (APR-DRG) software, a grouping algorithm to categorize inpatient discharges with similar treatment characteristics requiring similar hospital resources.

1. For SFY 2023, each hospital's CMI was calculated as follows:

A. A dataset of complete inpatient stays was established using MO HealthNet fee-for-service claims and managed care encounters combined for calendar years 2019 and 2020. A two-year dataset was used to account for the potential impact of changes to hospital utilization, costs, and mix of patients due to the COVID-19 Public Health Emergency.

B. Interim claims where multiple claims cover a single inpatient stay were combined into single claims covering the complete inpatient stay.

C. The 3M™ APR-DRG grouping software was applied to the inpatient dataset, using version 38 of the grouper. Each inpatient stay was assigned to a single DRG and severity of illness level. Each APR-DRG is associated with a relative weight reflecting the relative amount of resources required to care for similar stays, compared to an average inpatient stay. APR-DRG weights are provided by 3M™ and are calculated based on a national all-payer population.

D. The national weights were recentered to reflect the average resource requirements within the MO HealthNet population, including both fee-for-service and managed care encounter inpatient stays. Recentered weights are calculated by dividing the APR-DRG national weights by the average casemix for all hospitals. The average casemix is calculated as the sum of the national weights for each inpatient stay divided by the number of stays for all hospitals.

E. A hospital-specific CMI is calculated by summing the MO HealthNet recentered weights for each inpatient stay and dividing the total by the number of inpatient stays for the hospital.

2. For SFY 2024 and forward, the basis of the case mix index will be determined by the Division based on combined inpatient stays from the second and third prior calendar years, the current version of the 3M™ APR-DRG grouper, relative weights appropriate for the MO HealthNet population, and the SFY in which an AAP is being calculated.

*[(D)](E)* Charity care. Results from a provider's policy to provide health care services free of charge or a reduction in charges because of the indigence or medical indigence of the patient.

*[(E)](F)* Contractual allowances. Difference between established rates for covered services and the amount paid by third-party payers under contractual agreements.

*[(F)](G)* Cost report. A cost report details, for purposes of both Medicare and MO HealthNet reimbursement, the cost of rendering covered services for the fiscal reporting period. The Medicare/Medicaid Uniform Cost Report contains the forms utilized in filing the cost report. The Medicare/Medicaid Cost Report version 2552-10 (CMS 2552-10) shall be used for fiscal years beginning on and after May 1, 2010.

*[(G)] Critical access. Hospitals which meet the federal definition found in section 1820(c)(2)(B) of the Social Security Act. A Missouri expanded definition of critical access shall also include hospitals which meet the federal definitions of both a rural referral center and sole community provider and is adjacent to at least one (1) county that has a Medicaid eligible population of at least twenty-five percent (25%) of the total population of the county or hospitals which are the sole community hospital located in a county that has a Medicaid population of at least twenty-five percent (25%) of the total population of the county.*

*(H) Disproportionate share reimbursement. The disproportionate share payments are described in 13 CSR 70-15.220.*

*(I) Effective date.*

1. The plan effective date shall be October 1, 1981.

2. The adjustment effective date shall be thirty (30) days after notification to the hospital that its reimbursement rate has been changed unless modified by other sections of the plan.]

*(H) Division. Unless otherwise designated, division refers to the MO HealthNet Division (MHD) a division of the Department of Social Services charged with the administration of the MO HealthNet program.*

*[(J)](I) [MO HealthNet] Medicaid inpatient days. [MO HealthNet] Medicaid inpatient days are paid [MO HealthNet] Medicaid days for inpatient hospital services as reported by the Medicaid Management Information System (MMIS).*

*[(K)] Medicare rate. The Medicare rate is the rate established on the basis of allowable cost as defined by applicable Medicare standards and principles of reimbursement (42 CFR parts 405 and 413) as determined by the servicing fiscal intermediary based on yearly hospital cost reports.]*

*[(L)](J) Nonreimbursable items. For purposes of reimbursement of reasonable cost, the following are not subject to reimbursement:*

1. Allowances for return on equity capital;

2. Amounts representing growth allowances in excess of the intensity allowance, profits, efficiency bonuses, or a combination of these;

3. Cost in excess of the principal of reimbursement specified in 42 CFR chapter IV, part 413; and

4. Costs or services specifically excluded or restricted in this *[plan]* rule or the MO HealthNet hospital provider manual.

*[(M)] Per diem rates. The per diem rates shall be determined from the individual hospital cost report in accordance with section (3) of this regulation.]*

**[(N)](K) Reasonable cost.** The reasonable cost of inpatient hospital services is an individual hospital's *[MO HealthNet] Medicaid [per diem]* cost per day as determined in accordance with *[the general plan rate calculation from section (3)] section (4)* of this regulation using the base year cost report.

**[(O)](L) Specialty [p/Pediatric [h/Hospital].** An inpatient pediatric acute care facility which—

1. Is licensed as a hospital by the Missouri Department of Health and Senior Services under Chapter 197 of the *Missouri Revised Statutes*;

2. Has been granted substantive waivers by the Missouri Department of Health and Senior Services from compliance with material hospital licensure requirements governing a) the establishment and operation of an emergency department, and b) the provision of pathology, radiology, laboratory, and central services; and

3. Is not licensed to operate more than sixty (60) inpatient beds.

**[(P)](M) Trend factor.** The trend factor is a measure of the change in costs of goods and services purchased by a hospital during the course of one (1) year.

**[(Q)] Children's hospital.** An acute care hospital operated primarily for the care and treatment of children under the age of eighteen (18) years old and which has designated in its licensure application at least sixty-five percent (65%) of its total licensed beds as a pediatric unit.]

**[(R)](N) [FRA] Federal Reimbursement Allowance (FRA).** The fee assessed to hospitals for the privilege of engaging in the business of providing inpatient health care in Missouri. The FRA shall be an allowable cost to the hospital. The *[Federal Reimbursement Allowance [FRA/]]* is identified in 13 CSR 70-15.110. Effective January 1, 1999, the assessment shall be an allowable cost.

**[(S)](O) [Incorporates] Incorporation by Reference.** This rule incorporates by reference the following:

1. The Hospital Provider Manual is incorporated by reference and made a part of this rule as published by the Department of Social Services, MO HealthNet Division, 615 Howerton Court, Jefferson City, MO 65109, at its website at <https://dssruletracker.mo.gov/dss-proposed-rules/welcome.action>, March 6, 2020] <http://manuals.momed.com/manuals/>, June 8, 2022. This rule does not incorporate any subsequent amendments or additions; and

2. Medicare/Medicaid Cost Report CMS 2552-10, which is incorporated by reference and made a part of this rule as published by the Centers for Medicare *[and] & Medicaid Services (CMS)* at its website <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Paper-Based-Manuals-Items/CMS021935.html>, *[February 18, 2020]* June 8, 2022. This rule does not incorporate any subsequent amendments or additions.

3. 42 CFR 405, which is incorporated by reference and made a part of this rule as published by CMS at its website <https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-405?toc=1>, June 8, 2022. This rule does not incorporate any subsequent amendments or additions.

4. 42 CFR 413, which is incorporated by reference and made a part of this rule as published by CMS at its website <https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-413?toc=1>, June 8, 2022. This rule does not incorporate any subsequent amendments or additions.

**[(3) Per Diem Reimbursement Rate Computation.** Each hospital shall receive a MO HealthNet per diem rate based on the following computation:

(A) The per diem rate shall be determined from the 1995 base year cost report in accordance with the following formula:

$$\text{Per Diem} = \frac{(\text{OC} * \text{TI})}{\text{MPD}} \frac{\text{CMC}}{\text{MPDC}}$$

1. OC—The operating component is the hospital's total

allowable cost (TAC) less CMC;

2. CMC—The capital and medical education component of the hospital's TAC;

3. MPD—Medicaid inpatient days;

4. MPDC-MPD—Medicaid patient days for capital costs as defined in paragraph (3)(A)3. with a minimum utilization of sixty percent (60%) as described in paragraph (5)(C)8.;

5. TI—Trend indices. The trend indices are applied to the OC of the per diem rate. The trend index for SFY 1995 is used to adjust the OC to a common fiscal year end of June 30. The adjusted OC shall be trended through SFY 2001;

6. TAC—Allowable inpatient routine and special care unit expenses, ancillary expenses, and graduate medical education costs will be added to determine the hospital's total allowable cost (TAC);

7. The per diem shall not exceed the average MO HealthNet inpatient charge per diem as determined from the base year cost report and adjusted by the TI;

8. The per diem shall be adjusted for rate increases granted in accordance with subsection (5)(F) for allowable costs not included in the base year cost report; and

(B) Trend Indices (TI). Trend indices starting in SFY 2016 will be determined based on the Hospital Market Basket index as published in Healthcare Cost Review by Institute of Health Systems (IHS), or equivalent publication, regardless of any changes in the name of the publication or publisher, for each State Fiscal Year (SFY).

1. The per diem rate shall be reduced as necessary to avoid any negative Direct Medicaid payments computed in accordance with 13 CSR 70-15.015.

2. A facility previously enrolled for participation in the MO HealthNet Program, which either voluntarily or involuntarily terminates its participation in the MO HealthNet Program and which reenters the MO HealthNet Program, will receive the same inpatient rate and outpatient rate as the previous owner/operator. Such facility will also receive the same Direct Medicaid Add-On Payment and Uninsured Add-On Payment as the previous owner/operator if the facility reenters the MO HealthNet Program during the same state fiscal year. If the facility does not reenter during the same state fiscal year, the Direct Medicaid Add-On Payment and Uninsured Add-On Payment will be determined based on the applicable base year data (i.e., fourth prior year cost report for the Direct Medicaid Payment; see 13 CSR 70-15.220 for the applicable data for the Uninsured Add-On Payment). If the facility does not have the applicable base year data, the Direct Medicaid Add-On Payment and the Uninsured Add-On Payment will be based on the most recent audited data available and will include annual trend factor adjustments from the year subsequent to the cost report period through the state fiscal year for which the payments are being determined.

(4) Per Diem Rate—New Hospitals.

(A) In the absence of adequate cost data, a new facility's initial MO HealthNet rate shall be ninety percent (90%) of the average-weighted, statewide per diem rate for the year it became certified to participate in the MO HealthNet program until a prospective rate is determined on the facility's rate setting cost report as set forth below in paragraph (4)(A)1. The facility's rate setting cost report shall be the first full fiscal year cost report. If the facility's first full fiscal year cost report does not include any Medicaid costs, the facility shall continue to receive the initial rate, and the prospective rate will be determined from the facility's second full fiscal year cost report. If the facility's second full fiscal year cost report does not include any Medicaid cost, the initial rate shall become the facility's prospective rate and shall be effective

the date the facility was enrolled in the MO HealthNet program. The effective date for facilities whose prospective rate was based on the rate setting cost report shall be the first day of the SFY that the rate setting cost report is the base year cost report for determining the Direct Medicaid Add-On Payment as described in 13 CSR 70-15.015.

1. *Prospective Per Diem Reimbursement Rate Computation.* Each new hospital shall receive a MO HealthNet prospective per diem rate based on the sum of the following components:

A. *Total Allowable Cost, less Graduate Medical Education cost, adjusted by the Trend Indices in subsection (3)(B) from the year subsequent to the rate setting cost report period through the state fiscal year for which the rate is being determined, divided by Medicaid Inpatient Days; plus*

B. *Graduate Medical Education cost divided by Medicaid Inpatient Days.*

2. The per diem rate shall not exceed the average MO HealthNet inpatient charge per day as determined from the rate setting cost report as adjusted by the applicable Trend Indices.

3. The per diem rate shall be adjusted for rate increases granted in accordance with subsection (5)(F) for allowable costs not included in the rate setting cost report.

4. The per diem rate shall be reduced as necessary to avoid any negative Direct Medicaid Payments computed in accordance with 13 CSR 70-15.015.

(B) In addition to the MO HealthNet rate determined by subsection (4)(A), the MO HealthNet per diem rate for a new hospital licensed after February 1, 2007, shall include an adjustment for the hospital's estimated Direct Medicaid Add-On Payment per patient day, as determined in 13 CSR 70-15.015, until the facility's prospective rate is set in accordance with subsection (4)(A). The facility's Direct Medicaid Add-On adjustment will then no longer be included in the per diem rate but shall be calculated as a separate Add-On Payment, as set forth in 13 CSR 70-15.015.]

[(5)](3) Reporting Requirements.

(A) Cost Reports.

1. Each hospital participating in the MO HealthNet [p]Program shall submit a cost report in the manner prescribed by the [state MO HealthNet agency] division. The cost report shall be submitted within five (5) calendar months after the close of the reporting period. The period of a cost report is defined in 42 CFR 413.24(f). [A single extension, not to exceed thirty (30) days, may be granted upon the request of the hospital and the approval of the MO HealthNet Division when the provider's operation is significantly affected due to extraordinary circumstances over which the provider had no control such as fire or flood. The request must be in writing and postmarked prior to the first day of the sixth month following the hospital's fiscal year end.]

A. All cost reports shall be submitted and certified by an officer or administrator of the hospital.

B. If a cost report is more than ten (10) days past due, the Division may withhold fifty thousand dollars (\$50,000) in MO HealthNet payments from the hospital until the hospital submits the cost report. If the MO HealthNet payment is less than fifty thousand dollars (\$50,000), the entire payment will be withheld. Upon the Division's or its authorized contractor's receipt of the cost report prepared in accordance with this regulation, the payment that was withheld will be released to the hospital.

C. A single extension, not to exceed thirty (30) days, may be granted upon the request of the hospital and the approval of the Division when the hospital's operation is significantly affected due to extraordinary circumstances over which the hospital had

no control, such as fire or flood. The request must be in writing and postmarked prior to the first day of the sixth month following the hospital's fiscal year end.

2. The change of control[, or ownership[, or termination]] of [or by] a hospital of participation in the program requires that the hospital submit a cost report for the period ending with the date of change of control[, or ownership[, or termination]] within five (5) calendar months after the close of the reporting period. [No extensions in the submitting of cost reports shall be allowed when a termination of participation has occurred.]

[A. If a provider notifies, in writing, the director of the Institutional Reimbursement Unit of the division prior to the change of control, ownership, or termination of participation in the MO HealthNet program, the division will withhold all remaining payments from the selling provider until the cost report is filed. Upon receipt of a cost report prepared in accordance with this regulation, any payment that was withheld will be released to the selling provider.

B. If the director of the Institutional Reimbursement Unit does not receive, in writing, notification of a change of control or ownership upon learning of a change of control or ownership, fifty thousand dollars (\$50,000) of the next available MO HealthNet payment, after learning of the change of control or ownership, will be withheld from the provider identified in the current MO HealthNet participation agreement until a cost report is filed. If the MO HealthNet payment is less than fifty thousand dollars (\$50,000), the entire payment will be withheld. Once the cost report prepared in accordance with this regulation is received, the payment will be released to the provider identified in the current MO HealthNet participation agreement.]

A. Upon learning of a change of control or ownership, the Division may withhold fifty thousand dollars (\$50,000) of the next available MO HealthNet payment from the hospital identified in the current MO HealthNet participation agreement until the cost report is filed. If the MO HealthNet payment is less than fifty thousand dollars (\$50,000), the entire payment will be withheld. Once the cost report prepared in accordance with this regulation is received, the payment will be released to the hospital identified in the current MO HealthNet participation agreement.

[C.]B. The [MO HealthNet] Division may, at its discretion, delay the withholding of funds specified in subparagraph/s/ [(5)](A)2.A. and B.](3)(A)2.A. until the cost report is due based on assurances satisfactory to the division that the cost report will be timely filed. A request jointly submitted by the buying and selling [provider] entities may provide adequate assurances. The buying [provider] entity must accept responsibility for ensuring timely filing of the cost report and authorize the division to immediately withhold fifty thousand dollars (\$50,000) if the cost report is not timely filed.

3. [All cost reports shall be submitted and certified by an officer or administrator of the provider. Failure to file a cost report, within the period prescribed in this subsection, may result in the impositions of sanctions as described in 13 CSR 70-3.030.] The termination of or by a hospital of participation in the MO HealthNet program requires that the hospital submit a cost report for the period ending with the date of termination within five (5) calendar months from the date of the CMS Tie-Out Notice. No extension in the submitting of cost reports shall be allowed when a termination of participation has occurred.

A. Upon learning of the termination, the Division may withhold fifty thousand dollars (\$50,000) of the next available MO HealthNet payment from the hospital until the cost report is filed. If the MO HealthNet payment is less than fifty thousand dollars (\$50,000), the entire payment will be withheld. Upon the Division's or its authorized contractor's receipt of the cost report prepared in accordance with this regulation, the payment that was withheld will be released to the hospital.



4. Amended cost reports or other supplemental. The division or **its authorized contractor** will notify the hospital by letter when the *[desk review] audit* of its cost report is completed. Since this data *[may]* will be used in the calculation of *per diem* rates, *[direct payments, trended costs, or uninsured add-on]* and other **Medicaid** payments, the hospital shall review the *[desk review] audited cost report* data *[and the schedule of key data elements]* and submit amended or corrected data to the division or **its authorized contractor** within fifteen (15) days. Data received after the fifteen- (15-) day deadline will not be considered by the division for *per diem* rates, *[direct payments, trended costs, or uninsured]* or other **Medicaid** payments unless the hospital requests in writing and receives an extension to file additional information prior to the end of the fifteen- (15-) day deadline.

(B) Records.

1. All hospitals are required to maintain financial and statistical records in accordance with 42 CFR 413.20. For purposes of this plan, statistical and financial records shall include beneficiaries' medical records and patient claim logs separated for inpatient and outpatient services billed to and paid for by MO HealthNet (excluding cross-over claims) respectively. *[Separate logs for inpatient and outpatient services should be maintained for MO HealthNet participants covered by managed care.]* All records must be available upon request to representatives, employees, or contractors of the MO HealthNet program, Missouri Department of Social Services, General Accounting Office (GAO), or the United States Department of Health and Human Services (HHS). The content and organization of the inpatient and outpatient logs shall include the following:

A. A separate *[MO HealthNet]* log for each fiscal year must be maintained by either date of service or date of payment *[by MO HealthNet]* for claims and all adjustments of those claims for services provided in the fiscal period. Lengths of stay covering two (2) fiscal periods should be recorded by date of admission. The information from the *[MO HealthNet]* log should be used to complete the Medicaid worksheet in the hospital's cost report;

*[B. Data required to be recorded in logs for each claim include:*

*(I) Participant name and MO HealthNet number;*

*(II) Dates of service;*

*(III) If inpatient claim, number of days paid for by MO HealthNet, classified by adults and peds, each sub-provider, newborn, or specific type of intensive care;*

*(IV) Charges for paid inpatient days and inpatient ancillary charges for paid days classified by cost center as reported in the cost report or allowed outpatient services, classified by cost center as reported on cost report;*

*(V) Noncovered charges combined under a separate heading;*

*(VI) Total charges;*

*(VII) Any partial payment made by third-party payers (claims paid equal to or in excess of MO HealthNet payment rates by third-party payers shall not be included in the log);*

*(VIII) MO HealthNet payment received or the adjustment taken; and*

*(IX) Date of remittance advice upon which paid claim or adjustment appeared;]*

*[C.]B.* A year-to-date total must appear at the bottom of each log page or after each applicable group total, or a summation page of all subtotals for the fiscal year activity must be included with the log; and

*[D.]C.* Not to be included in the *[outpatient]* logs are **denied** claims or line item *[outpatient]* charges *[denied by MO HealthNet or claims or charges paid from an established MO HealthNet fee schedule]*. This would include payments for hospital-based physicians and certified registered nurse anesthetists billed by the hospital on a professional services claim, *[payments*

*for certain specified clinical diagnostic laboratory services,]* or payments for services provided by the hospital through enrollment as a MO HealthNet provider-type other than hospital *[outpatient]*.

2. Records of related organizations, as defined by 42 CFR 413.17, must be available upon demand to those individuals or organizations as listed in paragraph *[(5)(B)1.] (3)(B)1.* of this rule.

*[3. The MO HealthNet Division shall retain all uniform cost reports submitted for a period of at least three (3) years following the date of submission of the reports and will maintain those reports pursuant to the record-keeping requirements of 42 CFR 413.20. If an audit by, or on behalf of, the state or federal government has begun but is not completed at the end of the three- (3-) year period, or if audit findings have not been resolved at the end of the three- (3-) year period, the reports shall be retained until resolution of the audit findings.*

4. *The MO HealthNet Division shall maintain any responses received on this plan, subsequent changes to this plan, and rates for a period of three (3) years from the date of receipt.*

*(C) New, Expanded, or Terminated Services.* A hospital, at times, may offer to the public new or expanded inpatient services which may require Certificate of Need (CON) approval, or may permanently terminate a service.

1. A state hospital, i.e., one owned or operated by the board of curators as provided for in Chapter 172, RSMo, or one owned or operated by the Department of Mental Health, may offer new or expanded inpatient services to the public provided it receives legislative appropriations for the project. A state hospital may submit a request for inpatient rate reconsideration if the project meets or exceeds a cost threshold of one (1) million dollars for capital expenditures or one (1) million dollars for major medical equipment expenditures as described in 19 CSR 60-50.300.

2. Nonstate hospitals may also offer new or expanded inpatient services to the public, and incur costs associated with the additions or expansions which may qualify for inpatient rate reconsideration requests. Such projects may require a Certificate of Need (CON). Rate reconsideration requests for projects requiring CON review must include a copy of the CON program approval. Nonstate hospitals may request inpatient rate reconsiderations for projects not requiring review by the CON program, provided each project meets or exceeds a cost threshold of one (1) million dollars for capital expenditures as described in 19 CSR 60-50.300.

3. A hospital (state or nonstate) will have six (6) months after the new or expanded service project is completed and the service is offered to the public to submit a request for inpatient rate reconsideration, along with a budget of the project's costs. The rate reconsideration request and budget will be subject to desk review and audit. Upon completion of the desk review and audit, the hospital's inpatient reimbursement rates may be adjusted, if indicated. Failure to submit a request for rate reconsideration and project budget within the six- (6-) month period shall disqualify the hospital from receiving a rate increase prior to recognizing the increase through the trended cost calculation (direct Medicaid payments). Failure to submit a request shall not prohibit the division from reducing the rate in the case of a terminated service.

4. Failure to submit a budget concerning terminated services may result in the imposition of sanctions as described in 13 CSR 70-3.030.

5. The effective date for any increase granted under this subsection shall be no earlier than the first day of the month following the MO HealthNet Division's final determination on rate reconsideration.

6. Any inpatient rate reconsideration request for new,

expanded, or terminated services must be submitted in writing to the MO HealthNet Division and must specifically and clearly identify the issue and total dollar amount involved. The total dollar amount must be supported by generally accepted accounting principles. The hospital shall demonstrate the adjustment is necessary, proper, and consistent with efficient and economical delivery of covered patient care services. The hospital will be notified in writing of the agency's decision within sixty (60) days of receipt of the hospital's written request or within sixty (60) days of receipt of any additional documentation or clarification which may be required, whichever is later. Failure to submit requested information within the sixty- (60-) day period shall be grounds for denial of the request. If the state does not respond within the sixty- (60-) day period, the request shall be deemed denied.

7. Rate adjustments due to new or expanded services will be determined as total allowable project cost (i.e., the sum of annual depreciation, annualized interest expense, and annual additional operating costs) multiplied by the ratio of total inpatient costs (less skilled nursing facility (SNF) and swing bed cost) to total hospital cost as submitted on the most recent cost report filed with the agency as of the review date divided by total acute care patient days including all special care units and nursery, but excluding swing bed days.

8. Total acute care patient days (excluding nursery and swing bed days) must be at least sixty percent (60%) of total possible bed days. Total possible bed days will be determined using the number of licensed beds times three hundred sixty-five (365) days. If the days, including neonatal units, are less than sixty percent (60%), the sixty percent (60%) number plus newborn days will be used to determine the rate increase. This computation will apply to capital costs only.

9. Major medical equipment costs included in rate reconsideration requests shall not include costs to replace current major medical equipment if the replacement does not result in new or expanded inpatient services. The replacement of inoperative or obsolete major medical equipment, by itself, does not qualify for rate reconsideration, even if the new equipment costs at least one (1) million dollars.]

(D) Audits.

1. A comprehensive hospital audit program shall be established in cooperation with the Missouri Medicare fiscal intermediary. Under the terms of the Common Audit Agreement, the Medicare intermediary shall perform the following:

- A. Desk review all hospital cost reports;
- B. Determine the scope and format for on-site audits;
- C. Perform field audits when indicated in accordance with Title XIX principles; and
- D. Submit to the state agency the final Title XVIII cost report with respect to each provider.

(E) Adjustments to Rates. The prospectively determined individual hospital's reimbursement rate may be adjusted only under the following circumstances:

1. When information contained in the cost report is found to be intentionally misrepresented. The adjustment shall be made retroactive to the date of the original rate. This adjustment shall not preclude the MO HealthNet Division from imposing any sanctions authorized by any statute or rule; or

2. When rate reconsideration is granted in accordance with subsection (5)(F).

(F) Rate Reconsideration.

1. Rate reconsideration may be requested under this subsection for changes in allowable cost which occur sub-

sequent to the base period described in subsection (3)(A). The effective date for any increase granted under this subsection shall be no earlier than the first day of the month following the MO HealthNet Division's final determination on rate reconsideration.

2. The following may be subject to review under procedures established by the MO HealthNet Division:

A. New, expanded, or terminated services as detailed in subsection (5)(C);

B. When the hospital experiences extraordinary circumstances which may include, but are not limited to, an act of God, war, or civil disturbance; and

C. Per diem rate adjustments for critical access hospitals.

(I) Critical access hospitals meeting either the federal definition or the Missouri expanded definition may request per diem rate adjustments in accordance with this subsection. The per diem rate increase will result in a corresponding reduction in the direct Medicaid payment.

(a) Hospitals which meet the federal definition as a critical access hospital will have a per diem rate equal to one hundred percent (100%) of their estimated MO HealthNet cost per day as determined in 13 CSR 70-15.015.

(b) Hospitals which meet the Missouri expanded definition as a critical access hospital will have a per diem rate equal to seventy-five percent (75%) of their estimated MO HealthNet cost per day as determined in 13 CSR 70-15.015. This includes new hospitals meeting the Missouri expanded definition as a critical access hospital whose interim MO HealthNet rate was calculated in accordance with subsection 13 CSR 70-15.015.

3. The following will not be subject to review under these procedures:

A. The use of Medicare standards and reimbursement principles;

B. The method for determining the trend factor;

C. The use of all-inclusive prospective reimbursement rates; and

D. Increased costs for the successor owner, management, or leaseholder that result from changes in ownership, management, control, operation, or leasehold interests by whatever form for any hospital previously certified at any time for participation in the MO HealthNet program, except a review may be conducted when a hospital changes from nonprofit to proprietary or vice versa to recognize the change in its property taxes, see paragraph (5)(E)4.

4. As a condition of review, the MO HealthNet Division may require the hospital to submit to a comprehensive operational review. The review will be made at the discretion of the MO HealthNet Division and may be performed by it or its designee. The findings from any such review may be used to recalculate allowable costs for the hospital.

5. The request for an adjustment must be submitted in writing to the MO HealthNet Division and must specifically and clearly identify the issue and the total dollar amount involved. The total dollar amount must be supported by generally acceptable accounting principles. The hospital shall demonstrate the adjustment is necessary, proper, and consistent with efficient and economical delivery of covered patient care services. The hospital will be notified in writing of the agency's decision within sixty (60) days of receipt of the hospital's written request or within sixty (60) days of receipt of any additional documentation or clarification which may be required, whichever is later. Failure to submit requested information within the sixty- (60-) day period shall be grounds for denial of the request. If the state does not respond within the sixty- (60-) day period, the request shall be deemed denied.

(G) *Sanctions.* Sanctions may be imposed against a provider in accordance with 13 CSR 70-3.030 and other applicable state and federal regulations.

*[(6) Outlier Adjustment for Children Under the Age of Six (6).*

(A) *Effective for admissions beginning on or after July 1, 1991, outlier adjustments for medically necessary inpatient services involving exceptionally high cost or exceptionally long lengths of stay for MO HealthNet-eligible children under the age of six (6) will be made to hospitals meeting the criteria under this plan and, for MO HealthNet-eligible infants under the age of one (1), will be made to any other MO HealthNet hospital except for specialty pediatric hospitals.*

1. *The following criteria must be met to be eligible for outlier adjustments for children one (1) year of age to children under six (6) years of age:*

A. *If the facility offered nonemergency obstetric services as of December 21, 1987, there must be at least two (2) obstetricians with staff privileges at the hospital who have agreed to provide obstetric services to individuals entitled to these services under the Missouri Medicaid plan. In the case of a hospital located in a rural area (area outside of a metropolitan statistical area, as defined by the federal Executive Office of Management and Budget), the term obstetrician includes any physician with staff privileges at the hospital to perform nonemergency obstetric procedures. This section does not apply to hospitals either with inpatients predominantly under eighteen (18) years of age or which did not offer nonemergency obstetric services as of December 21, 1987;*

B. *As determined from the fourth prior year desk-reviewed cost report, the facility must have either—*

(I) *A Medicaid inpatient utilization rate (MIUR) at least one (1) standard deviation above the state's mean MIUR for all Missouri hospitals. The MIUR will be expressed as the ratio of total Medicaid days (TMD) provided under a state plan divided by the provider's total number of inpatient days (TNID). The state's mean MIUR will be expressed as the ratio of the sum of the total number of the Medicaid days for all Missouri hospitals divided by the sum of the total patient days for the same Missouri hospitals. Data for hospitals no longer participating in the program will be excluded;*

$$MIUR = \frac{TMD}{TNID}$$

or

(II) *A low-income utilization rate (LIUR) in excess of twenty-five percent (25%). The LIUR shall be the sum (expressed as a percentage) of the fractions, calculated as follows:*

(a) *Total MO HealthNet patient revenues (TMPR) paid to the hospital for patient services under a state plan plus the amount of the cash subsidies (CS) directly received from state and local governments, divided by the total net revenues (TNR) (charges, minus contractual allowances, discounts, and the like) for patient services plus the CS; and*

(b) *The total amount of the hospital's charges for patient services attributable to charity care (CC) (care provided to individuals who have no source of payment, third-party, or personal resources) less CS directly received from state and local governments in the same period, divided by the total amount of the hospital's charges (THC) for patient services. The total patient charges attributed to CC shall not include any contractual allowances and discounts other than for indigent patients not eligible for MO HealthNet under a state plan;*

$$LIUR = \frac{TMPR + CS}{TNR + CS} + \frac{CC - CS}{THC}$$

C. *As determined from the fourth prior year desk-reviewed cost report, the hospital—*

(I) *Has an unsponsored care ratio of at least ten percent (10%). The unsponsored care ratio is determined as the sum of bad debts and CC divided by TNR and also meets either of the criteria in subparagraph (6)(A)1.B.; or*

(II) *Ranks in the top fifteen (15) in the number of Medicaid inpatient days provided by that hospital compared to Medicaid patient days provided by all hospitals, and the hospitals also have a Medicaid nursery utilization ratio greater than thirty-five percent (35%) as computed by dividing Title XIX nursery and neonatal days by total nursery and neonatal days; or*

(III) *Operated a neonatal intensive care unit with a ratio of Missouri Medicaid neonatal patient days to Missouri Medicaid total patient days in excess of nine percent (9%) reported or verified by the division from the fourth prior year cost report;*

D. *As determined from the fourth prior year desk-reviewed cost report—*

(I) *The acute care hospital has an unsponsored care ratio of at least sixty-five percent (65%) and is licensed for less than fifty (50) inpatient beds; or*

(II) *The acute care hospital has an unsponsored care ratio of at least sixty-five percent (65%) and is licensed for fifty (50) inpatient beds or more and has an occupancy rate of more than forty percent (40%); or*

(III) *The hospital is owned or operated by the Board of Curators as defined in Chapter 172, RSMo, or their successors; or*

(IV) *The hospital is a public hospital operated by the Department of Mental Health primarily for the care and treatment of mental disorders; and*

E. *As determined from the fourth prior year desk-reviewed cost report, hospitals which annually provide more than five thousand (5,000) Title XIX days of care and whose Title XIX nursery days represent more than fifty percent (50%) of the hospital's total nursery days.*

2. *The following criteria must be met for the services to be eligible for outlier review:*

A. *The patient must be a MO HealthNet-eligible infant under the age of one (1) year, or for hospitals that meet the criteria under paragraph (6)(A)1. a MO HealthNet-eligible child under the age of six (6) years, for all dates of service presented for review;*

B. *Hospitals requesting outlier review for children one (1) year of age to children under six (6) years of age must have qualified under paragraph (6)(A)1. for the state fiscal year corresponding with the fiscal year end of the cost report referred to in paragraph (6)(A)6.; and*

C. *One (1) of the following conditions must be satisfied:*

(I) *The total reimbursable charges for dates of service [as described in paragraph (6)(A)4. must be at least one hundred fifty percent (150%) of the sum of total third-party liabilities and MO HealthNet inpatient claim payments for that claim; or*

(II) *The dates of service must exceed sixty (60) days and less than seventy-five percent (75%) of the total service days was reimbursed by MO HealthNet.*

3. *Claims for all dates of service eligible for outlier review must—*

A. *Have been submitted to the MO HealthNet Division fiscal agent or the managed care health plan in their entirety for routine claims processing, and claim payment must have*

been made before the claims are submitted to the division for outlier review; and

B. Be submitted for outlier review with all documentation as required by the MO HealthNet Division no later than ninety (90) days from the last payment made by the fiscal agent or the managed care health plan through the normal claims processing system for those dates of service.

4. Information for outlier reimbursement processing will be determined from claim charges and MO HealthNet payment data, submitted to the MO HealthNet Division fiscal agent or managed care health plan, by the hospital through normal claim submission. If the claim information is determined to be incomplete as submitted, the hospital may be asked to provide claim data directly to the MO HealthNet Division for outlier review.

5. The claims may be reviewed for—

A. Medical necessity at an inpatient hospital level-of-care;

B. Appropriateness of services provided in connection with the diagnosis;

C. Charges that are not permissible per the MO HealthNet Division; policies established in the hospital provider manual and hospital bulletins; and

D. If the hospital is asked to provide claim information, the hospital will need to provide an affidavit vouching to the accuracy of final payments by the MO HealthNet Division, managed care health plans, and other third-party payors. The calculation of outlier payments will be based on the standard hospital payment defined in subparagraph (6)(A)7.B.

6. After the review, reimbursable costs for each claim will be determined using the following data from the most recent Medicaid hospital cost report filed by June 1 of each year:

A. Average routine (room and board) costs for the general and special care units for all days of the stay eligible per the outlier review;

B. Ancillary cost-to-charge ratios applied to claim ancillary charges determined eligible for reimbursement per the outlier review; and

C. No cost will be calculated for items such as malpractice insurance premiums, interns and residents, professional services, or return on equity.

7. Each state fiscal year, outlier adjustment payments for each hospital will be made for all claims submitted before March 1 of the preceding state fiscal year which satisfy all conditions in paragraphs (6)(A)1.-5. The payments will be determined for each hospital as follows:

A. Sum all reimbursable costs per paragraph (6)(A)6. for all applicable outlier claims to equal total reimbursable costs;

B. For those claims, subtract third-party payments and MO HealthNet payments, which includes both per diem payments and Direct Medicaid Add-On payments, from total reimbursable costs to equal excess cost; and

C. Multiply excess costs by fifty percent (50%).

(B) Effective for admissions beginning on or after July 1, 1997, outlier adjustments shall also be made for MO HealthNet participants enrolled in managed care. All criteria listed under subsection (6)(A) applies to managed care outlier submissions.

(C) Effective for admissions beginning on or after May 1, 2017, outlier adjustments will only be made for the fee for service claims. All criteria listed under subsection (6)(A) will continue to be applied to the fee for service outlier submissions.]

(C) Cost Report Audits.

1. The examination or inspection of a hospital's cost report,

files, and any other supporting documentation by the Division or its authorized contractor. The Division or its authorized contractor may perform the following types of audits:

A. Level I Audit—Requires a more narrow scope of review of hospital cost reports, files, and any other additional information requested and submitted to the Division or its authorized contractor. The limited review may include items such as comparative analysis of a hospital's cost report data to industry data, a review of a hospital's prior year data to determine any outliers that may warrant further review, requesting additional details of the reported information, all of which could lead to potential adjustment(s) after such further review, as well as, making and standard adjustments, etc. Level I Audits may be provided off-site;

B. Level II Audit—Requires a desk review of hospital cost reports, files, and any other additional information requested and submitted to the Division or its authorized contractor. The desk review may include review procedures in a Level I Audit plus a more detailed analysis of a hospital's cost report data to identify items that would require further review including requesting additional details of the reported information, documentation to support amounts reflected in the cost report, etc. Level II Audits may be provided off-site; or

C. Level III Audits – Requires an in depth audit, including an on-site review, of hospital cost reports, files, and any other additional information requested and submitted to the Division or its authorized contractor. The Level III Audit will require an in depth analysis of a hospital's cost report data and an on-site verification of cost report items deemed necessary through a risk assessment or other analyses, etc. Level III Audits will require some portion of the hospital's records review be provided on-site

(4) Inpatient *Per Diem* Reimbursement Rate Computation. Effective for dates of service beginning July 1, 2022, each Missouri hospital shall receive a Missouri Medicaid *per diem* rate based on the following computation:

(A) The *per diem* shall be determined from the base year cost report in accordance with the following formula:

$PER\ DIEM = ((TAC / MPD) * TI) + MIP\ FRA$

1. MIP FRA—Medicaid Inpatient Share of FRA. The Medicaid inpatient share of the FRA Assessment will be calculated by dividing the hospital's Medicaid patient days from the base year cost report by total hospital patient days from the base year cost report to arrive at the Medicaid utilization percentage. This percentage is then multiplied by the inpatient FRA assessment for the current SFY to arrive at the increased allowable Medicaid cost. This cost is then divided by the estimated Medicaid days for the current SFY to arrive at the increased Medicaid cost per day;

2. MPD—Medicaid inpatient days from the base year cost report;

3. TI—Trend indices. The trend indices are applied to the TAC per day of the *per diem* rate. The trend index for the base year is used to adjust the TAC per day to a common fiscal year end of June 30. The adjusted TAC per day shall be trended through the current SFY;

4. TAC—Medicaid allowable inpatient routine and special care unit costs, and ancillary costs, from the base year cost report, will be added to determine the hospital's Medicaid total allowable cost (TAC);

5. The *per diem* for private free-standing psychiatric hospitals shall be the greater of one-hundred percent (100%) of the SFY 2022 weighted average statewide *per diem* rate for private free-standing psychiatric hospitals or the *per diem* as calculated in (4)(A).;

6. The *per diem* shall not exceed the average Medicaid inpatient charge *per diem* as determined from the base year cost report and adjusted by the TI;

7. The *per diem* shall be adjusted for rate increases granted

in accordance with Subsections IV.C. and IV.D.

8. If the hospital does not have a base year cost report, the inpatient *per diem* will be the weighted average statewide *per diem* rate as determined in section (5).

(B) Trend Indices (TI). For trend indices for State Fiscal Year 2018 and forward, refer to the Hospital Market Basket index as published in Healthcare Cost Review by Institute of Health Systems (IHS), or equivalent publication, regardless of any changes in the name of the publication or publisher, for each State Fiscal Year (SFY).

(C) Adjustments to Rates. A hospital's inpatient *per diem* rate may be adjusted only under the following circumstances:

1. When information contained in the cost report is found to be intentionally misrepresented. Such adjustment shall be made retroactive to the date of the original rate. Such adjustment shall not preclude the Division from imposing any sanctions authorized by any statute or regulation.

2. When a rate reconsideration is granted in accordance with subsection (4)(D).

(D) Rate Reconsideration

1. Rate reconsideration may be requested under this subsection for changes in allowable costs which occur subsequent to the base year cost report described in subsection (4)(A). The effective date for any increase granted under this subsection shall be no earlier than the first day of the month following the Division's final determination of the rate reconsideration.

2. The following may be subject to review under procedures established by the Division:

A. New or expanded inpatient services. A hospital, at times, may offer to the public new or expanded inpatient services which may require Certificate of Need (CON) approval.

(I) A state hospital, i.e., one owned or operated by the Board of Curators as provided for in Chapter 172, RSMo, or one owned or operated by the Department of Mental Health, may offer new or expanded inpatient services to the public provided it receives legislative appropriations for the project. A state hospital may submit a request for inpatient rate reconsideration if the project meets or exceeds a cost threshold of one (1) million dollars for capital expenditures or one (1) million dollars for major medical equipment expenditures as described in 19 CSR 60-50.300.

(II) Non-state hospitals, may also offer new or expanded inpatient services to the public, and incur costs associated with the additions or expansions which may qualify for inpatient rate reconsideration requests. Such projects may require a CON. Rate reconsideration requests for projects requiring CON review must include a copy of the CON program approval. Non-state hospitals may request inpatient rate reconsiderations for projects not requiring review by the CON program, provided each project meets or exceeds a cost threshold of one (1) million dollars for capital expenditures as described in 19 CSR 60-50.300.

(III) A hospital (state or non-state) will have six (6) months after the new or expanded service project is completed and the service is offered to the public to submit a request for inpatient rate reconsideration, along with a budget of the project's costs. The rate reconsideration request and budget will be subject to review. Upon completion of the review, the hospital's inpatient reimbursement rate may be adjusted, if indicated. Failure to submit a request for rate reconsideration and project budget within the six (6) month period shall disqualify the hospital from receiving a rate increase prior to recognizing the increase through the trended cost calculation.

(IV) Rate reconsiderations due to new or expanded services will be determined as total allowable project cost (i.e., the sum of annual depreciation, annualized interest expense and annual additional operating costs) multiplied by the ratio of total inpatient costs (less SNF and swing bed cost) to total hospital cost as submitted on the most recent cost report filed with the Division or its authorized contractor as of the review date divided

by total acute care patient days including all special care units and nursery, but excluding swing bed days. The most recent cost report filed must be audited prior to the finalization of the rate reconsideration.

(V) Total acute care patient days (excluding nursery and swing bed days) must be at least sixty percent (60%) of total possible bed days. Total possible bed days will be determined using the number of licensed beds times three hundred sixty-five (365) days. If the total acute care patient days (excluding nursery and swing bed days) are less than sixty percent (60%) of total possible bed days, the sixty percent (60%) number plus nursery days will be used to determine the rate increase. If the total acute care patient days (excluding nursery and swing bed days) are at least sixty percent (60%) of total possible bed days, the total acute care patient days plus nursery days will be used to determine the rate increase. This computation will apply to capital costs only.

(VI) Major medical equipment costs included in rate reconsideration requests shall not include costs to replace current major medical equipment if the replacement does not result in new or expanded inpatient services. The replacement of inoperative or obsolete major medical equipment, by itself, does not qualify for rate reconsideration, even if the new equipment costs at least one (1) million dollars.

B. When the hospital experiences extraordinary circumstances which may include, but are not limited to, an act of God, war or civil disturbance.

3. The following will not be subject to review under these procedures:

A. The use of Medicare standards and reimbursement principles;

B. The method for determining the trend factor;

C. The use of all-inclusive prospective reimbursement rates; and

D. Increased costs for the successor owner, management or leaseholder that result from changes in ownership, management, control, operation or leasehold interests by whatever form for any hospital previously certified at any time for participation in the Medicaid program.

4. The request for a rate reconsideration must be submitted in writing to the Division and must specifically and clearly identify the project and the total dollar amount involved. The total dollar amount must be supported by generally accepted accounting principles. The hospital shall demonstrate the rate reconsideration is necessary, proper, and consistent with efficient and economical delivery of covered patient care services. The hospital will be notified of the Division's decision in writing within sixty (60) days of receipt of the hospital's written request or within sixty (60) days of receipt of any additional documentation or clarification which may be required, whichever is later. Failure to submit requested information within the sixty (60) day period, shall be grounds for denial of the request.

(5) *Per Diem* Reimbursement Rate Computation for New Hospitals. Effective for dates of service beginning July 1, 2022, each new Missouri hospital's rate setting cost report shall be the first full fiscal year cost report, which includes inpatient Medicaid costs, otherwise the hospital shall continue to receive the weighted average statewide *per diem* rate as determined below.

(A) Acute care hospitals. In the absence of adequate cost data, a new hospital's Medicaid rate shall be one-hundred percent (100%) of the weighted average statewide *per diem* rate for acute care hospitals until a prospective rate is determined on the hospital's rate setting cost report, in accordance with Section (4).

(B) Free-standing psychiatric hospitals. In the absence of adequate cost data, a new hospital's Medicaid rate shall be one-hundred percent (100%) of the weighted average statewide *per diem* rate for free-standing psychiatric hospitals, excluding the state psychiatric hospitals, until a prospective rate is determined on the

hospital's rate setting cost report, in accordance with Section (4).

(C) Long Term Acute Care hospitals. In the absence of adequate cost data, a new hospital's Medicaid rate shall be one-hundred percent (100%) of the weighted average statewide *per diem* rate for long term acute care hospitals until a prospective rate is determined on the hospital's rate setting cost report, in accordance with section (4).

(D) Rehabilitation hospitals. In the absence of adequate cost data, a new hospital's Medicaid rate shall be one-hundred percent (100%) of the weighted average statewide *per diem* rate for rehabilitation hospitals until a prospective rate is determined on the hospital's rate setting cost report, in accordance with section (4).

**(6) Acuity Adjustment Payment (AAP)**

(A) Beginning with SFY 2023, hospitals that meet the requirements set forth below shall receive an AAP. Ownership type of the hospital is determined based on the Type of Control reported on Schedule S-2, Part I, Line 21, Column 1 of the hospital's base year cost report. For purposes of this section, Medicaid payments received shall include the following payments.

1. For SFY 2022, the Medicaid *per diem* payments, Direct Medicaid payments, GME payments, and CO payments.

2. For SFY 2023 and forward, the Medicaid *per diem* payments, AAP, PC payment, SLP, GME payments, and CO payments.

(B) Private Ownership. A hospital shall receive an AAP if the hospital's MO HealthNet case mix index is greater than a threshold set annually by the Division. The preliminary AAP is calculated by multiplying the hospital's MO HealthNet case mix index times the estimated Medicaid payments for the coming SFY. If the hospital's estimated Medicaid payments for the coming SFY plus the preliminary AAP exceeds the hospital's prior SFY Medicaid payments received by a stop-gain percentage, the preliminary AAP will be reduced so the estimated Medicaid payments for the coming SFY plus the final AAP is equal to the stop-gain percent of the hospital's prior SFY Medicaid payments received. If no reduction is necessary, the preliminary AAP shall be considered final.

(C) Non-State Government Owned or Operated (NSGO) Ownership. A hospital shall receive an AAP if the hospital's MO HealthNet case mix index is greater than a threshold set annually by the Division. The preliminary AAP is calculated by multiplying the hospital's MO HealthNet case mix index times the estimated Medicaid payments for the coming SFY. If the hospital's estimated Medicaid payments for the coming SFY plus the preliminary AAP exceeds the hospital's prior SFY Medicaid payments received by a stop-gain percentage, the preliminary AAP will be reduced so the estimated Medicaid payments for the coming SFY plus the final AAP is equal to the stop-gain percent of the hospital's prior SFY Medicaid payments received. If no reduction is necessary the preliminary AAP shall be considered final.

(D) The annual final AAP will be calculated for each hospital at the beginning of each SFY. The annual amount will be paid out over the number of financial cycles during the SFY.

**(7) Poison Control (PC) Payment**

(A) The PC payment shall be determined for hospitals which operated a Poison Control Center during the base year and which continues to operate a Poison Control Center. The PC payment shall reimburse the hospital for the Medicaid share of the total Poison Control cost and shall be determined as follows:

1. The total Poison Control cost from the base year cost report will be divided by the total hospital days from the base year cost report to determine a cost per day. This cost per day will then be multiplied by the estimated days for the SFY for which the PC payment is being calculated.

2. The annual final PC payment will be calculated for each eligible hospital at the beginning of each SFY. The annual amount will be paid out over the number of financial cycles during the SFY.

**(8) Stop Loss Payment (SLP)**

(A) Beginning with SFY 2023 hospitals that meet the requirements set forth below shall receive a SLP. Ownership type of the hospital is determined based on the Type of Control reported on Schedule S-2, Part I, Line 21, Column 1 of the hospital's base year cost report. For purposes of this section, Medicaid payments received shall include the following payments.

1. For SFY 2022, the Medicaid *per diem* payments, Direct Medicaid payments, GME payments, and CO payments.

2. For SFY 2023 and forward, the Medicaid *per diem* payments, AAP, PC payment, SLP, GME payments, and CO payments.

(B) Private Ownership. Total estimated Medicaid payments for the coming SFY for each hospital shall include any final AAP and PC payment. The total estimated Medicaid payments for each hospital shall be subtracted from the hospital's prior SFY Medicaid payments received then summed to calculate a total increase or decrease in payments for the entire private ownership group. A positive result represents a decrease in payments and a negative amount represents an increase in payments. If the result is a decrease in total payments to the private ownership group, this amount shall represent the total Stop Loss Amount.

1. SLP will be made if a total Stop Loss Amount was calculated in (8)(B). Each hospital that shows a decrease in Medicaid payments shall receive a SLP in the amount of the decrease in payments unless the sum of each hospital's SLP is greater than the total Stop Loss Amount. If the sum is greater than the total Stop Loss Amount, each hospital's SLP shall be calculated by multiplying the total Stop Loss Amount times the ratio of the hospital's decrease in Medicaid payments to the total Stop Loss Amount.

(C) NSGO Ownership. Total estimated Medicaid payments for the coming SFY for each hospital shall include any final AAP and PC payment. The total estimated Medicaid payments for each hospital shall be subtracted from the hospital's prior SFY Medicaid payments received then summed to calculate a total increase or decrease in payments for the entire NSGO ownership group. A positive result represents a decrease in payments and a negative amount represents an increase in payments. If the result is a decrease in total payments to the NSGO ownership group, this amount shall represent the total Stop Loss Amount.

1. SLP will be made if a total Stop Loss Amount was calculated in (8)(C). Each hospital that shows a decrease in Medicaid payments shall receive a SLP in the amount of the decrease in payments unless the sum of each hospital's SLP is greater than the total Stop Loss Amount. If the sum is greater than the total Stop Loss Amount, each hospital's SLP shall be calculated by multiplying the total Stop Loss Amount times the ratio of the hospital's decrease in Medicaid payments to the total Stop Loss Amount.

(D) The annual SLP will be calculated for each hospital at the beginning of each SFY. The annual amount will be paid out over the number of financial cycles during the SFY.

(9) Medicaid Graduate Medical Education (GME) Payments. Effective beginning with SFY 2023, a GME payment calculated as the sum of the Intern and Resident Based GME payment and the GME Stop Loss payment, shall be made to any acute care hospital that provides graduate medical education.

(A) Intern and Resident (I&R) Based GME payment. The I&R Based GME payment will be based on the per I&R Medicaid allocated GME costs not to exceed a maximum amount per I&R. The Division will determine the number of full time equivalent

(FTE) I&Rs. Total GME costs will be determined using Worksheet A of the base year cost report adjusted by the trend index. Total GME costs is multiplied by the ratio of Medicaid days to total days to determine the Medicaid allocated GME costs which is then divided by the number of FTE I&Rs to calculate the Medicaid allocated cost per I&R. The I&R Based GME payment is calculated as the number of FTE I&Rs multiplied by the minimum established by the Division or the Medicaid allocated cost per I&R.

(B) GME Stop Loss payment. The total I&R Based GME payment for each hospital shall be subtracted from the hospital's prior SFY GME payments received then summed to calculate a total increase or decrease in payments for the entire group of hospitals that provide graduate medical education. A positive result represents a decrease in payments and a negative amount represents an increase in payments. If the result is a decrease in total payments to the hospitals this amount shall represent the total GME Stop Loss Amount.

GME Stop Loss Payments will be made if a total GME Stop Loss Payment Amount was calculated in the paragraph above. Each hospital that shows a decrease in GME Medicaid payments shall receive a GME Stop Loss Payment in the amount of the decrease in payments unless the sum of each hospital's GME Stop Loss Payment is greater than the total GME Stop Loss Amount. If the sum is greater than the total GME Stop Loss Amount, each hospital's GME Stop Loss Payment shall be calculated by multiplying the total GME Stop Loss Amount times the ratio of the hospital's decrease in GME Medicaid payments to the total GME Stop Loss Amount.

(C) Hospitals who implement a GME program prior to July 1st of the SFY and do not have a base year cost report to determine GME costs shall receive an I&R Based GME payment based on the statewide average Per Resident Amount (PRA) determined as follows:

1. The number of FTE I&Rs shall be reported to the Division by June 1st prior to the beginning of the SFY in order to have a GME payment calculated.

2. The I&R Based GME payment shall be calculated as the number of FTE I&Rs multiplied by the Medicaid Capped Statewide Average PRA. The Medicaid Capped Statewide Average PRA is calculated as follows:

A. By applying a straight average to the list of facility PRA's with the following criteria:

(I) A facility's PRA used in the straight average shall be the minimum as established by the Division or the facility's actual PRA.

(D) The hospital's I&R Based GME Payment plus GME Stop Loss Payment, if applicable, will be calculated for each hospital at the beginning of each SFY. The annual amount will be paid on a quarterly basis during the SFY.

#### (10) Children's Outlier (CO) Payment—

(A) The outlier year is based on a discharge date between July 1 and June 30.

(B) Beginning July 1, 2022, for fee-for-service claims only, outlier payments for medically necessary inpatient services involving exceptionally high cost or exceptionally long lengths of stay for MO HealthNet-eligible children under the age of six (6) will be made to hospitals, meeting the Federal DSH requirements in paragraph (10)(B)1., and for MO HealthNet-eligible infants under the age of one (1) will be made to any other Missouri Medicaid hospital.

1. The following criteria must be met to be eligible for outlier payments for children one (1) year of age to children under six (6) years of age:

A. If the facility offered nonemergency obstetric services as of December 21, 1987, there must be at least two (2) obstetricians with staff privileges at the hospital who have agreed to provide

obstetric services to individuals entitled to these services under the Missouri Medicaid plan. In the case of a hospital located in a rural area (area outside of a metropolitan statistical area, as defined by the federal Executive Office of Management and Budget), the term obstetrician includes any physician with staff privileges at the hospital to perform nonemergency obstetric procedures. This section does not apply to hospitals either with inpatients predominantly under eighteen (18) years of age or which did not offer nonemergency obstetric services as of December 21, 1987;

B. As determined from the base year audited Medicaid cost report, the hospital must have either—

(I) A Medicaid inpatient utilization rate (MIUR) at least one (1) standard deviation above the state's mean MIUR for all Missouri hospitals. The MIUR will be expressed as the ratio of total Medicaid days (TMD) provided under a state plan divided by the provider's total number of inpatient days (TNID). The state's mean MIUR will be expressed as the ratio of the sum of the total number of the Medicaid days for all Missouri hospitals divided by the sum of the total patient days for the same Missouri hospitals. Data for hospitals no longer participating in the program will be excluded;

$$\text{MIUR} = \text{TMD} / \text{TNID}$$

or

(II) A low-income utilization rate (LIUR) in excess of twenty-five percent (25%). The LIUR shall be the sum (expressed as a percentage) of the fractions, calculated as follows:

(a) Total MO HealthNet patient revenues (TMPR) paid to the hospital for patient services under a state plan plus the amount of the cash subsidies (CS) directly received from state and local governments, divided by the total net revenues (TNR) (charges, minus contractual allowances, discounts, and the like) for patient services plus the CS; and

(b) The total amount of the hospital's charges for patient services attributable to charity care (CC) less CS directly received from state and local governments in the same period, divided by the total amount of the hospital's charges (THC) for patient services. The total patient charges attributed to CC shall not include any contractual allowances and discounts other than for indigent patients not eligible for MO HealthNet under a state plan;

$$\text{LIUR} = ((\text{TMPR} + \text{CS}) / (\text{TNR} + \text{CS})) + ((\text{CC} - \text{CS}) / \text{THC})$$

2. The following criteria must be met for the services to be eligible for outlier review:

A. The patient must be a MO HealthNet-eligible infant under the age of one (1) year, or for hospitals that meet the federal DSH requirements, a MO HealthNet-eligible child under the age of six (6) years, as of the date of discharge; and

B. One (1) of the following conditions must be satisfied:

(I) The total reimbursable charges for dates of service must be at least one hundred fifty percent (150%) of the sum of claim payments for each claim; or

(II) The dates of service must exceed sixty (60) days and less than seventy-five percent (75%) of the total service days were reimbursed by MO HealthNet.

3. Claims eligible for outlier review must—

A. Have been submitted in their entirety for claims processing; and

B. The claim must have been paid; and

C. An annual outlier file, for paid claims only, must be submitted to the division no later than December 31 of the second calendar year following the end of the outlier year (i.e. claims for outlier year 2022 are due no later than December 31, 2024).

4. After the review, reimbursable costs for each claim will be



determined using the following data from the audited Medicaid hospital cost report for the year ending in the same calendar year as the outlier year (i.e. Medicaid hospital cost reports ending in 2022 will be used for the 2022 outlier year):

A. Average routine (room and board) costs for the general and special care units for all days of the stay eligible per the outlier review; and

B. Ancillary cost-to-charge ratios applied to claim ancillary charges determined eligible for reimbursement per the outlier

5. The outlier payments will be determined for each hospital as follows:

A. Sum all reimbursable costs for all eligible outlier claims to equal total reimbursable costs;

B. Subtract total claim payments, which includes MO HealthNet claims payments, third party payments, and co-pays, from total reimbursable costs to equal excess cost; and

C. Multiply excess costs by fifty percent (50%).

#### (11) Safety Net Hospitals

(A) Inpatient hospital providers may qualify as a Safety Net Hospital based on the following criteria. Hospitals shall qualify for a period of only one (1) SFY and must requalify at the beginning of each SFY to continue their Safety Net Hospital designation.

1. If the facility offered non-emergency obstetric services as of December 21, 1987, there must be at least two (2) obstetricians with staff privileges at the hospital who have agreed to provide obstetric services to individuals entitled to those services under the Missouri Medicaid plan. In the case of a hospital located in a rural area (area outside of a Metropolitan Statistical Area, as defined by the federal executive Office of Management and Budget), the term obstetrician includes any physician with staff privileges at the hospital to perform non-emergency obstetric procedures. This section does not apply to hospitals either with inpatients predominantly under eighteen (18) years of age or which did not offer non-emergency obstetric services as of December 21, 1987;

2. As determined from the audited base year cost report, the facility must have either:

A. A Medicaid inpatient utilization rate (MIUR) at least one (1) standard deviation above the state's mean MIUR for all Missouri hospitals: The MIUR will be expressed as the ratio of total Medicaid days (TMD) (including such patients who receive benefits through a managed care entity) provided under a state plan divided by the provider's total number of inpatient days (TNID). The state's mean MIUR will be expressed as the ratio of the sum of the total number of Medicaid days for all Missouri hospitals divided by the sum of the total patient days for the same Missouri hospitals. Data for hospitals no longer participating in the program will be excluded. (Alternative language using CMS definition of mean MIUR.): The state's mean MIUR will be expressed as the ratio of the sum of all Medicaid participating hospitals' MIURs divided by the total number of Medicaid participating hospitals for a state plan year.

$$MIUR = TMD / TNID$$

or;

B. A low income utilization rate in excess of twenty-five percent (25%).

(I) The low-income utilization rate (LIUR) shall be the sum (expressed as a percentage) of the fractions, calculated as follows:

(a) Total Medicaid patient revenues (TMPR) paid to the hospital for patient services under a state plan (regardless of whether the services were furnished on a fee-for-service basis or

through a managed care entity) plus the amount of the cash subsidies (CS) directly received from state and local governments, divided by the total net revenues (TNR) (charges, minus contractual allowances, discounts etc.) For patient services plus the cash subsidies, and;

(b) The total amount of the hospital's charges for patient services attributable to charity care (CC) less cash subsidies directly received from state and local governments in the same period, divided by the total amount of the hospital's charges (THC) for patient services. The total patient charges attributed to charity care shall not include any contractual allowances and discounts other than for indigent patients not eligible for medical assistance under a State Plan.

$$LIUR = ((TMPR + CS) / (TNR + CS)) + ((CC - CS) / THC)$$

3. As determined from the audited base year cost report,

A. The acute care hospital has an unsponsored care ratio of at least sixty five percent (65%) and is licensed for less than fifty (50) inpatient beds; or

B. The acute care hospital has an unsponsored care ratio of at least sixty five (65%) and is licensed for fifty (50) inpatient beds or more and has an occupancy rate of more than forty percent (40%); or

C. A public non-state governmental acute care hospital with a LIUR of at least forty percent (40%) and a MIUR greater than one standard deviation from the mean, and is licensed for fifty (50) inpatient beds or more and has an occupancy rate of at least forty percent (40%); or

D. The hospital is owned or operated by the Board of Curators as defined in Chapter 172, RSMo; or

E. The hospital is a public hospital operated by the Department of Mental Health primarily for the care and treatment of mental disorders.

(12) Hospital Mergers. Hospitals that merge their operations under one Medicare and Medicaid provider number shall have their Medicaid reimbursement combined under the surviving hospital's (the hospital's whose Medicare and Medicaid provider number remained active) Medicaid provider number.

(A) The *per diem* rate for merged hospitals shall be calculated:

1. For the remainder of the SFY in which the merger occurred, the merged rate is calculated by multiplying each hospital's estimated Medicaid paid days by its *per diem* rate, summing the estimated *per diem* payments and estimated Medicaid paid days, and then dividing the total estimated *per diem* payments by the total estimated paid days to determine the weighted *per diem* rate. The effective date of the weighted *per diem* rate will be the date of the merger.

2. For subsequent SFYs, the *per diem* rate will be based on the combined data from the base year cost report for each facility.

(B) The Other Medicaid Payments, if applicable, shall be:

1. Combined under the surviving hospital's Medicaid provider number for the remainder of the SFY in which the merger occurred; and

2. Calculated for subsequent SFYs based on the combined data from the base year cost report for each facility.

//7//13) Payment Assurance. The state will pay each hospital, which furnishes the services in accordance with the requirements of the state plan, the amount determined for services furnished by the hospital according to the standards and methods set forth in the rules implementing the Hospital Reimbursement Program.

//8//14) Inappropriate Placements.

(A) The hospital *per diem* rate as determined under this plan and in effect on October 1, 1981, shall not apply to any participant who



is receiving inpatient hospital care when s/he is only in need of nursing home care.

1. If a hospital has an established intermediate care facility/skilled nursing facility (ICF/SNF) or SNF-only MO HealthNet rate for providing nursing home services in a distinct part setting, reimbursement for nursing home services provided in the inpatient hospital setting shall be made at the hospital's ICF/SNF or SNF-only rate.

2. No MO HealthNet payments will be made on behalf of any participant who is receiving inpatient hospital care and is not in need of either inpatient or nursing home care.

*[(9) MO HealthNet GME Add-On—A MO HealthNet Add-On determined for Graduate Medical Education (GME) costs shall be allocated based on the estimated effect of implementation of a MO HealthNet managed care system in accordance with this section.*

*(A) The MO HealthNet GME Add-On for MO HealthNet participants covered under a Managed Care Plan shall be determined using the base year cost report and paid in quarterly installments. The base year cost report shall be the fourth prior fiscal year (i.e., the base year for SFY 1999 is the FY 1995 cost report). The hospital per diem shall continue to include a component for GME related to MO HealthNet participants not included in a managed care system.*

*1. Total GME cost shall be multiplied by a managed care allocation factor which incorporates the estimated percentage of the hospital's MO HealthNet population included in a managed care system and the estimated implementation date for a managed care system. For example: If a hospital has 1) an annual GME cost of one hundred thousand dollars (\$100,000), 2) forty percent (40%) of their MO HealthNet days are related to MO HealthNet participants eligible for MO HealthNet managed care, and 3) the projected implementation date for managed care is October 1, 1995; the prorated GME Add-On is thirty thousand dollars (\$30,000).*

*2. The annual GME Add-On shall be paid in quarterly installments.*

*(10) Enhanced Graduate Medical Education (GME) Payment. An enhanced GME payment shall be made to any acute care hospital that provides graduate medical education (teaching hospital).*

*(A) The enhanced GME payment shall be computed in accordance with subsection (10)(B). The payment shall be made following the end of the state fiscal year. The enhanced GME payment for each state fiscal year shall be computed using the most recent cost data available when the enhanced GME payment is computed. If the cost report is less than or more than a twelve- (12-) month period, the cost report data will be adjusted to reflect a twelve- (12-) month period. The state share of the enhanced GME payment to a hospital that has cash subsidies shall come from funds certified by the hospital.*

*(B) The enhanced GME payment will be computed by first determining the percentage difference between the McGraw-Hill CPI index for hospital services and Medicare update factors applied to the per resident amounts from 1986 to the most recent SFY. For example, the percentage difference has been computed to be eighty-five and sixty-two one-hundredth percent (85.62%) for SFY 2000. The percentage difference is then multiplied by the MO HealthNet share of the aggregate approved amount reported on worksheet E-4 of the Medicare cost report (CMS 2552-10) for the fourth prior fiscal year and trended to the current state fiscal year. The resulting product is the enhanced GME payment.*

*(11) Hospital Mergers. Hospitals that merge their operations under one (1) Medicare and MO HealthNet provider number*

*shall have their MO HealthNet reimbursement combined under the surviving hospital's (the hospital whose Medicare and MO HealthNet provider number remains active) MO HealthNet provider number.*

*(A) The disproportionate share status of the merged hospital provider shall be—*

*1. The same as the surviving hospital's status was prior to the merger for the remainder of the state fiscal year in which the merger occurred; and*

*2. Determined based on the combined desk-reviewed data from the appropriate cost reports for the merged hospitals in subsequent fiscal years.*

*(B) The per diem rate for merged hospitals shall be calculated—*

*1. For the remainder of the state fiscal year in which the merger occurred by multiplying each hospital's estimated MO HealthNet paid days by its per diem rate, summing the estimated per diem payments and estimated MO HealthNet paid days, and then dividing the total estimated per diem payments by the total estimated paid days to determine the weighted per diem rate. The effective date of the weighted per diem rate will be the date of the merger. This merged rate will also be used in fiscal years following the effective date.*

*(C) The Direct Medicaid Payments, Uninsured Add-On Payments, and GME payments, if the surviving facility continues the GME program, shall be—*

*1. Combined under the surviving hospital's MO HealthNet provider number for the remainder of the state fiscal year in which the merger occurred; and*

*2. Calculated for subsequent state fiscal years based on the combined data from the appropriate cost report for each facility.]*

**(15) Directed Payments.** Effective July 1, 2022, the Missouri Medicaid managed care organizations shall make inpatient and outpatient directed payments to in-network hospitals pursuant to 42 CFR 438.6(c) as approved by the Centers for Medicare & Medicaid Services.

**AUTHORITY:** sections 208.153, 208.201, 660.017, and RSMo 2016, and section 208.152 RSMo Supp. [2020] 2021. This rule was previously filed as 13 CSR 40-81.050. Original rule filed Feb. 13, 1969, effective Feb. 23, 1969. For intervening history, please consult the **Code of State Regulations**. Emergency amendment filed June 14, 2022, effective July 1, 2022, expires Feb. 23, 2023. A proposed amendment covering this same material is published in this issue of the **Missouri Register**.

**PUBLIC COST: Fee For Service:** This emergency amendment is estimated to cost the state approximately \$448.7 million (State Share: \$151.5 million FRA and \$1.3 million IGT for DMH) in the time the emergency is effective. This emergency amendment is estimated to increase payments to public entities by approximately \$65.3 million in the time the emergency is effective.

**Directed Payments:** This emergency amendment is estimated to save the state approximately \$9.5 million (State Share: \$3.2 million FRA and \$0 million IGT for DMH) in the time the emergency is effective. This emergency amendment is estimated to cost public entities by approximately \$8.7 million in the time the emergency is effective.

**PRIVATE COST: Fee For Service:** This emergency amendment is estimated to increase payments to in-state private entities by approximately \$383.4 million in the time the emergency is effective.

**Directed Payments:** This emergency amendment is estimated to cost in-state private entities approximately \$785 thousand in the time the emergency is effective.

**FISCAL NOTE  
PUBLIC COST**

- I. **Department Title:** 13 Social Services  
**Division Title:** 70 MO HealthNet Division  
**Chapter Title:** 15 Hospital Program

<b>Rule Number and Name:</b>	13 CSR 70-15.010 Inpatient Hospital Services Reimbursement Methodology
<b>Type of Rulemaking:</b>	Emergency Amendment

**II. SUMMARY OF FISCAL IMPACT**

Affected Agency or Political Subdivision	Estimated Cost of Compliance in the Aggregate
<b>Other Government (Public) &amp; State Hospitals enrolled in MO HealthNet - 38</b>  <b>Department of Social Services, MO HealthNet Division</b>	<b>Fee-For-Service Impacts</b>  <b>Estimated impact for 6 months of SFY 2023:</b> <b>\$65.3 million</b>  <b>Estimated cost for 6 months of SFY 2023:</b> <b>Total \$448.7 million;</b> <b>State Share \$151.5 million (FRA)</b> <b>State Share \$1.3 million (IGT)</b>
<b>Other Government (Public) &amp; State Hospitals enrolled in MO HealthNet - 32</b>  <b>Department of Social Services, MO HealthNet Division</b>	<b>Directed Payments Impacts</b>  <b>Estimated cost for 6 months of SFY 2023:</b> <b>\$8.7 million</b>  <b>Estimated savings for 6 months of SFY 2023:</b> <b>Total \$9.5 million;</b> <b>State Share \$3.2 million (FRA)</b> <b>State Share \$0 million (IGT)</b>

**III. WORKSHEET**

<b><u>Fee-for-Service Impact:</u></b>			
<b><u>Other Government (Public) &amp; State Hospitals Impact:</u></b>			
<b><u>Estimated Impact for 6 Months of SFY 2023:</u></b>			
	FRA Fund	IGT Fund	Total
Estimated Impact to State Hospitals	\$18,321,736	\$3,878,513	\$22,200,249
Estimated Impact to Other Government (Public) Hospitals	\$43,076,920	0	\$43,076,920
Total Estimated Impact	\$61,398,656	\$3,878,513	\$65,277,169
State Share Percentage	34.0525%	34.0525%	34.0525%
Estimated State Share	\$20,907,777	\$1,320,730	\$22,228,508

<b>Department of Social Services, MO HealthNet Division Cost:</b>			
<b><u>Estimated Cost for 6 Months of SFY 2023:</u></b>			
	FRA Fund	IGT Fund	Total
Estimated Cost	(\$444,813,084)	(\$3,878,513)	(\$448,691,597)
State Share Percentage	34.0525%	34.0525%	34.0525%
Estimated State Share Cost	(\$151,469,975)	(\$1,320,730)	(\$152,790,706)

  

<b><u>Directed Payment Cost:</u></b>			
<b><u>Other Government (Public) &amp; State Hospitals Cost:</u></b>			
<b><u>Estimated Cost for 6 Months of SFY 2023:</u></b>			
	FRA Fund	IGT Fund	Total
Estimated Cost to State Hospitals	(\$2,042,236)	\$0	(\$2,042,236)
Estimated Cost to Other Government (Public) Hospitals	(\$6,696,064)	\$0	(\$6,696,064)
Total Estimated Cost	(\$8,738,300)	\$0	(\$8,738,300)
State Share Percentage	34.0525%	34.0525%	34.0525%
Estimated State Share	(\$2,975,610)	\$0	(\$2,975,610)

  

<b><u>Department of Social Services, MO HealthNet Division Savings:</u></b>			
<b><u>Estimated Savings for 6 Months of SFY 2023:</u></b>			
	FRA Fund	IGT Fund	Total
Estimated Savings	\$9,523,347	\$0	\$9,523,347
State Share Percentage	34.0525%	34.0525%	34.0525%
Estimated State Share Savings	\$3,242,938	\$0	\$3,242,938

#### IV. ASSUMPTIONS

The following regulations are impacted by the change to the hospital reimbursement methodology and the impact of all the regulations should be netted to arrive at the total impact. The net impact is a cost to the state of \$3.8 million for 6 months of SFY 2023.

13 CSR 70-15.010  
13 CSR 70-15.015  
13 CSR 70-15.220  
13 CSR 70-15.230

The fiscal impact is estimated based on historical utilization and enrollment. Other variables such as the length of the Federal Public Health Emergency and Medicaid Expansion enrollment may indirectly affect the hospital utilization both positively and negatively. Due to the uncertainty of these variables, the state will continue to monitor the impacts to the Managed Care Organizations and hospitals.

**FISCAL NOTE  
PRIVATE COST**

- I. Department Title:** 13 Social Services  
**Division Title:** 70 MO HealthNet Division  
**Chapter Title:** 15 Hospital Program

<b>Rule Number and Title:</b>	13 CSR 70-15.010 Inpatient Hospital Services Reimbursement Methodology
<b>Type of Rulemaking:</b>	Emergency Amendment

**II. SUMMARY OF FISCAL IMPACT**

Estimate of the number of entities by class which would likely be affected by the adoption of the rule:	Classification by types of the business entities which would likely be affected:	Estimate in the aggregate as to the cost of compliance with the rule by the affected entities:
In-State Hospitals – 100	Private Hospitals enrolled in MO HealthNet	FFS Estimated impact for 6 months of SFY 2023: \$383.4 million
In-State Hospitals - 99	Private Hospitals enrolled in MO HealthNet	Directed Payment Estimated cost for 6 months of SFY 2023: \$785 thousand

**III. WORKSHEET**

<b><u>Fee-for-Service Impact:</u></b>			
<b><u>In-State Private Hospitals Impact:</u></b>			
<b><u>Estimated Impact for 6 Months of SFY 2023:</u></b>			
	FRA Fund	IGT Fund	Total
Estimated Impact to In-State Private Hospitals	383,414,428	0	383,414,428
State Share Percentage	34.0525%	34.0525%	34.0525%
Estimated State Share	130,562,198	0	130,562,198

<b><u>Directed Payment Impact:</u></b>			
<b><u>In-State Private Hospitals Impact:</u></b>			
<b><u>Estimated Cost for 6 Months of SFY 2023:</u></b>			
	FRA Fund	IGT Fund	Total
Estimated Cost to In-State Private Hospitals	(785,047)	0	(785,047)
State Share Percentage	34.0525%	34.0525%	34.0525%
Estimated State Share	(267,328)	0	(267,328)

#### **IV. ASSUMPTIONS**

The following regulations are impacted by the change to the hospital reimbursement methodology and the impact of all the regulations should be netted to arrive at the total impact. The net impact is a cost to the state of \$3.8 million for 6 months of SFY 2023.

13 CSR 70-15.010

13 CSR 70-15.015

13 CSR 70-15.220

13 CSR 70-15.230

The fiscal impact is estimated based on historical utilization and enrollment. Other variables such as the length of the Federal Public Health Emergency and Medicaid Expansion enrollment may indirectly affect the hospital utilization both positively and negatively. Due to the uncertainty of these variables, the state will continue to monitor the impacts to the Managed Care Organizations and hospitals.

**Title 13—DEPARTMENT OF SOCIAL SERVICES**  
**Division 70—MO HealthNet Division**  
**Chapter 15—Hospital Program**

**EMERGENCY AMENDMENT**

**13 CSR 70-15.015 Direct Medicaid Payments.** The division is deleting section (1), renumbering as necessary, and amending the new section (1).

*PURPOSE:* This emergency amendment provides for the calculation of the Outpatient Direct Medicaid payments made on or after July 1, 2022. The division is removing the calculation of the Inpatient Direct Medicaid Payment.

*EMERGENCY STATEMENT:* This emergency amendment removes the Inpatient Direct Medicaid Payment from the hospital program. The Department of Social Services, MO HealthNet Division (MHD) finds that this emergency rule is necessary to preserve a compelling governmental interest as it allows the State Medicaid Agency to implement a new reimbursement model under 13 CSR 70-15.010, and to eliminate the old reimbursement model. The new reimbursement model is effective July 1, 2022. As a result, the MHD finds it necessary to preserve its compelling governmental interest in eliminating the Inpatient Direct Medicaid Payment by July 1, 2022, which requires an early effective date. A proposed amendment, which covers the same material, is published in this issue of the *Missouri Register*. The scope of this emergency amendment is limited to the circumstances creating the emergency and complies with the protections extended by the *Missouri* and *United States Constitutions*. The MHD believes this emergency amendment to be fair to all interested parties under the circumstances. This emergency amendment was filed June 14, 2022, becomes effective July 1, 2022, and expires February 23, 2023.

*[(1) Direct Medicaid Qualifying Criteria.*

(A) An inpatient hospital provider may qualify as a Disproportionate Share Hospital (DSH) based on the following criteria. Hospitals shall qualify as a DSH for a period of only one (1) state fiscal year (SFY) and must requalify at the beginning of each SFY to continue their DSH classification.

1. If the facility offered nonemergency obstetric services as of December 21, 1987, there must be at least two (2) obstetricians with staff privileges at the hospital who have agreed to provide obstetric services to individuals entitled to these services under the Missouri Medicaid plan. In the case of a hospital located in a rural area (area outside of a metropolitan statistical area, as defined by the federal Executive Office of Management and Budget), the term obstetrician includes any physician with staff privileges at the hospital to perform nonemergency obstetric procedures. This section does not apply to hospitals either with inpatients predominantly under eighteen (18) years of age or which did not offer nonemergency obstetric services as of December 21, 1987.

2. As determined from the fourth prior year audited cost report, the facility must have either—

A. A Medicaid inpatient utilization rate (MIUR) at least one (1) standard deviation above the state's mean MIUR for all Missouri hospitals. The MIUR will be expressed as the ratio of total Medicaid days (TMD) provided under a state plan divided by the provider's total number of inpatient days (TNID). The state's mean MIUR will be expressed as the ratio of the sum of the total number of the Medicaid days for all Missouri hospitals divided by the sum of the total patient days for the same Missouri hospitals. Data for hospitals no longer participating in the program will be excluded;

$$MIUR = TMD / TNID$$

or

B. A low-income utilization rate (LIUR) in excess of twenty-five percent (25%). The LIUR shall be the sum (expressed as a percentage) of the fractions, calculated as follows:

(I) Total MO HealthNet patient revenues (TMPR) paid to the hospital for patient services under a state plan plus the amount of the cash subsidies (CS) directly received from state and local governments, divided by the total net revenues (TNR) (charges, minus contractual allowances, discounts, and the like) for patient services plus the CS; and

(II) The total amount of the hospital's charges for patient services attributable to charity care (CC) (care provided to individuals who have no source of payment, third-party, or personal resources) less CS directly received from state and local governments in the same period, divided by the total amount of the hospital's charges (THC) for patient services. The total patient charges attributed to CC shall not include any contractual allowances and discounts other than for indigent patients not eligible for MO HealthNet under a state plan.

$$LIUR = ((TMPR + CS) / (TNR + CS)) + ((CC - CS) / (THC))$$

3. As determined from the fourth prior year audited cost report, the hospital—

A. Has an unsponsored care ratio of at least ten percent (10%). The unsponsored care ratio is determined as the sum of bad debts and CC divided by TNR and also meets either of the criteria in paragraph (1)(A)2.; or

B. Ranks in the top fifteen (15) in the number of Medicaid inpatient days provided by that hospital compared to Medicaid patient days provided by all hospitals, and the hospitals also have a Medicaid nursery utilization ratio greater than thirty-five percent (35%) as computed by dividing Title XIX nursery and neonatal days by total nursery and neonatal days; or

C. Operated a neonatal intensive care unit with a ratio of Missouri Medicaid neonatal patient days to Missouri Medicaid total patient days in excess of nine percent (9%) reported or verified by the division from the fourth prior year cost report.

4. As determined from the fourth prior year audited cost report—

A. The acute care hospital has an unsponsored care ratio of at least sixty-five percent (65%) and is licensed for less than fifty (50) inpatient beds; or

B. The acute care hospital has an unsponsored care ratio of at least sixty-five percent (65%) and is licensed for fifty (50) inpatient beds or more and has an occupancy rate of more than forty percent (40%); or

C. A public non-state governmental acute care hospital with an LIUR of at least fifty percent (50%) and an MIUR greater than one (1) standard deviation from the mean, and is licensed for fifty (50) inpatient beds or more and has an occupancy rate of at least forty percent (40%); or

D. The hospital is owned or operated by the Board of Curators as defined in Chapter 172, RSMo, or their successors; or

E. The hospital is a public hospital operated by the Department of Mental Health primarily for the care and treatment of mental disorders.

5. As determined from the fourth prior year audited cost report, hospitals which annually provide more than five thousand (5,000) Title XIX days of care and whose Title XIX nursery days represent more than fifty percent (50%) of the hospital's total nursery days.

(B) Those hospitals which meet the criteria established in paragraphs (1)(A)1., (1)(A)2., and (1)(A)4. shall be deemed safety net hospitals. Those hospitals which meet the criteria established in paragraphs (1)(A)1. and (1)(A)3. shall be deemed first tier Disproportionate Share Hospitals (DSH). Those hospitals which meet only the criteria established in paragraphs (1)(A)1. and (1)(A)2. or (1)(A)1. and (1)(A)5. shall be deemed second tier DSH.

*(2) Direct Medicaid Payments.]*

[(A)](1) Outpatient Direct Medicaid Payments. Outpatient Direct Medicaid payments will be made to hospitals for the following allowable MO HealthNet costs [not included in the per diem rate as calculated in 13 CSR 70-15.010(3)]:

[1.](A) The increased MO HealthNet costs resulting from the Federal Reimbursement Allowance (FRA) assessment becoming an allowable cost on January 1, 1999;

[2. The unreimbursed MO HealthNet costs applicable to the trend factor which is not included in the per diem rate;

3. The unreimbursed MO HealthNet costs for capital and medical education not included in the trended per diem cost as a result of the application of the sixty percent (60%) minimum utilization adjustment in 13 CSR 70-15.010(3)(A)4.;

4. The increased cost per day resulting from the utilization adjustment. The increased cost per day results from lower utilization of inpatient hospital services by MO HealthNet participants now covered by a managed care health plan;

5. The poison control adjustment shall be determined for hospitals which operated a poison control center during the base year and which continues to operate a poison control center in a MO HealthNet managed care region; and

6. The increased cost resulting from including out-of-state Medicaid days in total projected MO HealthNet days.]

(B) The MO HealthNet Division will calculate the Outpatient Direct Medicaid payment as follows:

1. [The MO HealthNet share of the inpatient FRA assessment will be calculated by dividing the hospital's inpatient Medicaid patient days by the total inpatient hospital patient days from the hospital's base cost report to arrive at the inpatient Medicaid utilization percentage. This percentage is then multiplied by the inpatient FRA assessment for the current SFY to arrive at the increased allowable MO HealthNet costs for the inpatient FRA assessment.] The [MO HealthNet] Medicaid share of the outpatient FRA assessment will be calculated by dividing the hospital's outpatient [MO HealthNet] Medicaid charges by the total outpatient hospital charges from the base year cost report to arrive at the [MO HealthNet] Medicaid utilization percentage. This percentage is then multiplied by the outpatient FRA assessment for the current SFY to arrive at the increased allowable [MO HealthNet] Medicaid cost[s] for the outpatient FRA assessment.

A. [Effective for payments made on or after May 1, 2017, only the Fee-for-Service (FFS) and Out-of-State (OOS) components of the MO HealthNet share of both the inpatient and outpatient FRA assessment will be included in the Direct Medicaid add-on payment;] Effective for payments made on or after July 1, 2022, only the Fee-for-Service (FFS) components of the Medicaid share of the outpatient FRA assessment will be included in the Outpatient Direct Medicaid Payment.

[2. The unreimbursed MO HealthNet costs are determined by subtracting the hospital's per diem rate from its trended per diem costs. The difference is multiplied by the estimated MO HealthNet patient days for the current SFY plus the out-of-state days from the fourth prior year cost report trended to the current SFY. The FFS days are determined from a regression analysis of the hospital's FFS days

from February 1999 through December of the second prior SFY. The managed care days are based on the FFS days determined from the regression analysis, as follows: The FFS days are factored up by the percentage of FFS days to the total of FFS days plus managed care days from the hospital's fourth prior year cost report. The difference between the FFS days and the FFS days factored up by the FFS days' percentage are the managed care days.

A. Effective for payments made on or after July 1, 2020, the estimated MO HealthNet patient days for the SFY shall be determined by adjusting the FFS days from the state's Medicaid Management Information System (MMIS) for the second prior calendar year (CY) (i.e., for SFY 2021, second prior CY would be 2019) by—

(I) The trend determined from a quadratic regression analysis of the hospital's FFS days from February 1999 through December of the second prior CY;

(II) The FFS days are factored up by one (1) of the following:

(a) For hospitals that are in a managed care extension region or a psychiatric hospital, the lower of the percentage of FFS days to the total of FFS days plus managed care days from the hospital's fourth prior year cost report or from the hospital's third prior year cost report to yield the estimated MO HealthNet patient days; or

(b) For hospitals that are not in a managed care extension region or a psychiatric hospital, the percentage of FFS days to the total of FFS days plus managed care days from the hospital's fourth prior year cost report to yield the estimated MO HealthNet patient days; and

(III) The difference between the FFS days and the FFS days factored up by the FFS days' percentage are the managed care days.

B. The trended cost per day is calculated by trending the base year costs per day by the trend indices as defined in 13 CSR 70-15.010(3)(B), using the rate calculation in 13 CSR 70-15.010(3)(A).

C. For hospitals that meet the requirements in paragraphs (1)(A)1., (1)(A)2., and (1)(A)4. of this rule (safety net hospitals), the base year cost report may be from the third, fourth, or fifth prior year. For hospitals that meet the requirements in paragraphs (1)(A)1. and (1)(A)3. of this rule (first tier DSH), the base year cost report may be from the third or fourth prior year. The MO HealthNet Division shall exercise its sole discretion as to which report is most representative of costs. For all other hospitals, the base year cost report is the fourth prior year. For any hospital that has both a twelve- (12-) month cost report and a partial year cost report, its base period cost report for that year will be the twelve- (12-) month cost report.

D. The trended cost per day does not include the costs associated with the FRA assessment, the application of minimum utilization, the utilization adjustment, and the poison control costs computed in paragraphs (2)(B)1., 3., 4., and 5.;

3. The minimum utilization costs for capital and medical education is calculated by determining the difference in the hospital's cost per day when applying the minimum utilization, as identified in 13 CSR 70-15.010(5)(C)4., and without applying the minimum utilization. The difference in the cost per day is multiplied by the estimated MO HealthNet patient days for the SFY;

4. The utilization adjustment cost is determined by estimating the number of MO HealthNet inpatient days the hospital will not provide as a result of the managed care health plans limiting inpatient hospital services. These days are multiplied by the hospital's cost per day to determine the total cost associated with these days. This cost is divided by the

remaining total patient days from its base period cost report to arrive at the increased cost per day. This increased cost per day is multiplied by the estimated MO HealthNet days for the current SFY to arrive at the MO HealthNet utilization adjustment.

A. Effective July 1, 2011, the utilization adjustment will no longer apply to any hospital other than safety net hospitals as defined in subsection (1)(B), children's hospitals as defined in 13 CSR 70-15.010(2)(Q), and specialty pediatric hospitals as defined in 13 CSR 70-15.010(2)(O). Children's hospitals and specialty pediatric hospitals will continue to receive fifty percent (50%) of the adjustment calculated in accordance with paragraph (2)(B)4. Safety net hospitals will continue to receive one hundred percent (100%) of the adjustment calculated in accordance with paragraph (2)(B)4.;

5. The poison control cost shall reimburse the hospital for the prorated MO HealthNet managed care cost. It will be calculated by multiplying the estimated MO HealthNet share of the poison control costs by the percentage of managed care participants to total MO HealthNet participants; and

6. Effective July 1, 2006, the costs for including out-of-state Medicaid days is calculated by subtracting the hospital's per diem rate from its trended per diem cost and multiplying this difference by the out-of-state Medicaid days as determined from the regression analysis performed using the out-of-state days from the fourth, fifth, and sixth prior year cost reports.

(C) For new hospitals that do not have a base cost report, Direct Medicaid Payments shall be estimated as follows:

1. Hospitals receiving Direct Medicaid Payments shall be divided into quartiles based on total beds;

2. Direct Medicaid Payments shall be individually summed by quartile and then divided by the total beds in the quartile to yield an average Direct Medicaid Payment per bed;

3. The number of beds for the new hospital without the base cost report shall be multiplied by the average Direct Medicaid Payment per bed to determine the hospital's estimated Direct Medicaid Payment for the current state fiscal year;

4. For a new hospital licensed after February 1, 2007, estimated total Direct Medicaid Payments for the current state fiscal year shall be divided by the estimated MO HealthNet patient days for the new hospital's quartile to obtain the estimated Direct Medicaid adjustment per patient day. This adjustment per day shall be added to the new hospital's MO HealthNet rate as determined in 13 CSR 70-15.010(4), so that the hospital's Direct Medicaid Payment per day is included in its per diem rate, rather than as a separate Add-On Payment. When the hospital's per diem rate is determined from its first full year cost report in accordance with 13 CSR 70-15.010(1)–(3), the facility's Direct Medicaid Payment will be calculated in accordance with subsection (2)(B) and reimbursed as an Add-On Payment rather than as part of the per diem rate. If the hospital is defined as a critical access hospital, its MO HealthNet per diem rate and Direct Medicaid Payment will be determined in accordance with 13 CSR 70-15.010(5)(F); and

5. A facility previously enrolled for participation in the MO HealthNet Program, which either voluntarily or involuntarily terminates its participation in the MO HealthNet Program and which reenters the MO HealthNet Program, shall have its Direct Medicaid Payments determined in accordance with 13 CSR 70-15.010(3)(B)2.]

filed as part of 13 CSR 70-15.010. Emergency rule filed April 30, 2020, effective May 15, 2020, expired Feb. 24, 2021. Original rule filed April 30, 2020, effective Nov. 30, 2020. Emergency amendment filed Aug. 26, 2021, effective Sept. 10, 2021, expired March 8, 2022. Amended: Filed Aug. 26, 2021, effective March 30, 2022. Emergency amendment filed June 14, 2022, effective July 1, 2022, expires Feb. 23, 2023. A proposed amendment covering this same material is published in this issue of the **Missouri Register**.

**PUBLIC COST:** This emergency amendment is estimated to save the state approximately \$484.8 million (State Share: \$162.7 million FRA and \$2.4 million IGT for DMH) in the time the emergency is effective. This emergency amendment is estimated to cost public entities by approximately \$84.4 million in the time the emergency is effective.

**PRIVATE COST:** This emergency amendment is estimated to cost in-state private entities approximately \$400.4 million in the time the emergency is effective.



**FISCAL NOTE  
PUBLIC COST**

- I. **Department Title:** 13 Social Services  
**Division Title:** 70 MO HealthNet Division  
**Chapter Title:** 15 Hospital Program

<b>Rule Number and Name:</b>	13 CSR 70-15.015 Direct Medicaid Payments
<b>Type of Rulemaking:</b>	Emergency Amendment

**II. SUMMARY OF FISCAL IMPACT**

Affected Agency or Political Subdivision	Estimated Cost of Compliance in the Aggregate
<b>Other Government (Public) &amp; State Hospitals enrolled in MO HealthNet - 38</b>	<b>Estimated cost for 6 months of SFY 2023: \$84.4 million</b>
<b>Department of Social Services, MO HealthNet Division</b>	<b>Estimated savings for 6 months of SFY 2023: Total \$484.8 million; State Share \$162.7 million (FRA) State Share \$2.4 million (IGT)</b>

**III. WORKSHEET**

<b>Other Government (Public) &amp; State Hospitals Cost:</b>			
<b>Estimated Cost for 6 Months of SFY 2023:</b>			
	FRA Fund	IGT Fund	Total
Estimated Cost to State Hospitals	\$31,004,817	\$6,944,552	\$37,949,369
Estimated Cost to Other Government (Public) Hospitals	\$46,470,178	\$0	\$46,470,178
Total Estimated Cost	\$77,474,995	\$6,944,552	\$84,419,547
State Share Percentage	34.0525%	34.0525%	34.0525%
Estimated State Share	\$26,382,173	\$2,364,794	\$28,746,966
<b>Department of Social Services, MO HealthNet Division Savings:</b>			
<b>Estimated Savings for 6 Months of SFY 2023:</b>			
	FRA Fund	IGT Fund	Total
Estimated Savings	\$477,836,862	\$6,944,552	\$484,781,414
State Share Percentage	34.0525%	34.0525%	34.0525%
Estimated State Share Savings	\$162,715,397	\$2,364,794	\$165,080,191

**IV. ASSUMPTIONS**

The following regulations are impacted by the change to the hospital reimbursement methodology and the impact of all the regulations should be netted to arrive at the total impact. The net impact is a cost to the state of \$3.8 million for 6 months of SFY 2023.

13 CSR 70-15.010

13 CSR 70-15.015

13 CSR 70-15.220

13 CSR 70-15.230

The fiscal impact is estimated based on historical utilization and enrollment. Other variables such as the length of the Federal Public Health Emergency and Medicaid Expansion enrollment may indirectly affect the hospital utilization both positively and negatively. Due to the uncertainty of these variables, the state will continue to monitor the impacts to the Managed Care Organizations and hospitals.

**FISCAL NOTE  
PRIVATE COST**

- I. Department Title:** 13 Social Services  
**Division Title:** 70 MO HealthNet Division  
**Chapter Title:** 15 Hospital Program

<b>Rule Number and Title:</b>	13 CSR 70-15.015 Direct Medicaid Payments
<b>Type of Rulemaking:</b>	Emergency Amendment

**II. SUMMARY OF FISCAL IMPACT**

<b>Estimate of the number of entities by class which would likely be affected by the adoption of the rule:</b>	<b>Classification by types of the business entities which would likely be affected:</b>	<b>Estimate in the aggregate as to the cost of compliance with the rule by the affected entities:</b>
In-State Hospitals – 100	Private Hospitals enrolled in MO HealthNet	Estimated cost for 6 months of SFY 2023: <b>\$400.4 million</b>

**III. WORKSHEET**

<b><u>In-State Private Hospitals Cost:</u></b>			
<b><u>Estimated Cost for 6 Months of SFY 2023:</u></b>			
	FRA Fund	IGT Fund	Total
Estimated Cost to In-State Private Hospitals	\$400,361,868	\$0	\$400,361,868
State Share Percentage	34.0525%	34.0525%	34.0525%
Estimated State Share	\$136,333,225	\$0	\$136,333,225

**IV. ASSUMPTIONS**

The following regulations are impacted by the change to the hospital reimbursement methodology and the impact of all the regulations should be netted to arrive at the total impact. The net impact is a cost to the state of \$3.8 million for 6 months of SFY 2023.

13 CSR 70-15.010  
13 CSR 70-15.015  
13 CSR 70-15.220  
13 CSR 70-15.230

The fiscal impact is estimated based on historical utilization and enrollment. Other variables such as the length of the Federal Public Health Emergency and Medicaid Expansion enrollment may indirectly affect the hospital utilization both positively and negatively. Due to the uncertainty of these variables, the state will continue to monitor the impacts to the Managed Care Organizations and hospitals.

**Title 13—DEPARTMENT OF SOCIAL SERVICES**  
**Division 70—MO HealthNet Division**  
**Chapter 15—Hospital Program**

**EMERGENCY AMENDMENT**

**13 CSR 70-15.110 Federal Reimbursement Allowance (FRA).** The division is amending section (1)(A)13.G., and adding section (5).

***PURPOSE:** This emergency amendment provides for the trend factor to be applied to the inpatient and outpatient adjusted net revenues to determine the inpatient and outpatient net revenues subject to the FRA assessment for SFY 2023. It also establishes the percentage of FRA that is taxed to Missouri hospitals for SFY 2023.*

***EMERGENCY STATEMENT:** This emergency amendment informs Missouri hospitals what FRA rate they will be assessed starting on July 1, 2022. The Department of Social Services (DSS), MO HealthNet Division (MHD) finds that this emergency amendment is necessary to preserve a compelling governmental interest of collecting state revenue in order to provide health care to individuals eligible for the MO HealthNet program and for the uninsured. Missouri Partnership Plan (MPP) between the Centers for Medicare & Medicaid Services (CMS) and the DSS, which establishes a process whereby CMS and DSS determine the permissibility of the funding source used by Missouri to fund its share of the MO HealthNet program, is based on a state fiscal year. In order to determine the trends for State Fiscal Year (SFY) 2023, all relevant information from the necessary sources must be available to MHD. The division uses the best information available when it starts calculating the assessment so it uses the trend published in the Fourth Quarter Healthcare Cost Review publication which is generally not available until January. The division must also analyze hospital revenue data, which is not complete until near the end of the SFY, in conjunction with the trend and hospital FRA funded payments to determine the appropriate level of assessment. Without this information, the trends cannot be determined. Therefore, due to timing of the receipt of this information and the necessary July 1, 2022 effective date, an emergency regulation is necessary. A proposed amendment, which covers the same material, is published in this issue of the *Missouri Register*. The scope of the emergency amendment is limited to the circumstances creating the emergency and complies with the protections extended by the *Missouri and United States Constitutions*. The MHD believes this emergency amendment to be fair to all interested parties under the circumstances. This emergency amendment was filed June 15, 2022, becomes effective July 1, 2022, and expires February 23, 2023.*

(1) Federal Reimbursement Allowance (FRA). FRA shall be assessed as described in this section.

(A) Definitions.

1. Bad debts—Amounts considered to be uncollectible from accounts and notes receivable that were created or acquired in providing services. Allowable bad debts include the costs of caring for patients who have insurance, but their insurance does not cover the particular service procedures or treatment rendered.

2. Base cost report—Desk-reviewed Medicare/Medicaid cost report. The Medicare/Medicaid Cost Report version 2552-96 (CMS 2552-96) shall be used for fiscal years ending on or after September 30, 1996. The Medicare/Medicaid Cost Report version 2552-10 (CMS 2552-10) shall be used for fiscal years beginning on and after May 1, 2010. When a hospital has more than one (1) cost report with periods ending in the base year, the cost report covering a full twelve- (12-) month period will be used. If none of the cost reports covers a full twelve (12) months, the cost report with the latest period will be used. If a hospital's base cost report is less than or greater than a twelve- (12-) month period, the data shall be adjusted, based on the number of months reflected in the base cost report, to a twelve- (12-) month period.

3. Charity care—Those charges written off by a hospital based on the hospital's policy to provide health care services free of charge or at a reduced charge because of the indigence or medical indigence of the patient.

4. Contractual allowances—Difference between established rates for covered services and the amount paid by third-party payers under contractual agreements. The Federal Reimbursement Allowance (FRA) is a cost to the hospital, regardless of how the FRA is remitted to the MO HealthNet Division, and shall not be included in contractual allowances for determining revenues. Any redistributions of MO HealthNet payments by private entities acting at the request of participating health care providers shall not be included in contractual allowances or determining revenues or cost of patient care.

5. Department—Department of Social Services.

6. Director—Director of the Department of Social Services.

7. Division—MO HealthNet Division, Department of Social Services.

8. Engaging in the business of providing inpatient health care—Accepting payment for inpatient services rendered.

9. Federal Reimbursement Allowance (FRA)—The fee assessed to hospitals for the privilege of engaging in the business of providing inpatient health care in Missouri. The FRA is an allowable cost to the hospital.

10. Fiscal period—Twelve- (12-) month reporting period determined by each hospital.

11. Gross hospital service charges—Total charges made by the hospital for inpatient and outpatient hospital services that are covered under 13 CSR 70-15.010.

12. Hospital—A place devoted primarily to the maintenance and operation of facilities for the diagnosis, treatment, or care for not fewer than twenty-four (24) hours in any week of three (3) or more nonrelated individuals suffering from illness, disease, injury, deformity, or other abnormal physical conditions; or a place devoted primarily to provide, for not fewer than twenty-four (24) hours in any week, medical or nursing care for three (3) or more nonrelated individuals. The term hospital does not include convalescent, nursing, shelter, or boarding homes as defined in Chapter 198, RSMo.

13. Hospital revenues subject to FRA assessment effective July 1, 2008—Each hospital's inpatient adjusted net revenues and outpatient adjusted net revenues subject to the FRA assessment will be determined as follows:

A. Obtain "Gross Total Charges" from Worksheet G-2, Line 25, Column 3 from CMS 2552-96, or Worksheet G-2, Line 28, Column 3 from CMS 2552-10, of the third prior year cost report (i.e., FRA fiscal year cost report) for the hospital. Charges shall exclude revenues for physician services. Charges related to activities subject to the Missouri taxes assessed for outpatient retail pharmacies and nursing facility services shall also be excluded. "Gross Total Charges" will be reduced by the following:

(I) "Nursing Facility Charges" from Worksheet C, Part I, Line 35, Column 6 from CMS 2552-96, or Worksheet C, Part I, Line 45, Column 6 from CMS 2552-10;

(II) "Swing Bed Nursing Facility Charges" from Worksheet G-2, Line 5, Column 1 from CMS 2552-96, or Worksheet G-2, Line 6, Column 1 from CMS 2552-10;

(III) "Nursing Facility Ancillary Charges" as determined from the Department of Social Services, MO HealthNet Division, nursing home cost report. (Note: To the extent that the gross hospital charges, as specified in subparagraph (1)(A)13.A. above, include long-term care charges, the charges to be excluded through this step shall include all long-term care ancillary charges including skilled nursing facility, nursing facility, and other long-term care providers based at the hospital that are subject to the state's provider tax on nursing facility services.);

(IV) "Distinct Part Ambulatory Surgical Center Charges" from Worksheet G-2, Line 22, Column 2 from CMS 2552-96, or Worksheet G-2, Line 25, Column 2 from CMS 2552-10;

(V) “Ambulance Charges” from Worksheet C, Part I, Line 65, Column 7 from CMS 2552-96, or Worksheet C, Part I, Line 95, Column 7 from CMS 2552-10;

(VI) “Home Health Charges” from Worksheet G-2, Line 19, Column 2 from CMS 2552-96, or Worksheet G-2, Line 22, Column 2 from CMS 2552-10;

(VII) “Total Rural Health Clinic Charges” from Worksheet C, Part I, Column 7, Lines 63.50–63.59 from CMS 2552-96, or Worksheet C, Part I, Column 7, Line 88 and subsets from CMS 2552-10; and

(VIII) “Other Non-Hospital Component Charges” from Worksheet G-2, Lines 6, 8, 21, 21.02, 23, and 24 from CMS 2552-96, or Worksheet G-2, Lines 5, 7, 9, 21, 24, 26, and 27 from CMS 2552-10;

B. Obtain “Net Revenue” from Worksheet G-3, Line 3, Column 1. The state will ensure this amount is net of bad debts and other uncollectible charges by survey methodology;

C. “Adjusted Gross Total Charges” (the result of the computations in subparagraph (1)(A)13.A.) will then be further adjusted by a hospital-specific collection-to-charge ratio determined as follows:

(I) Divide “Net Revenue” by “Gross Total Charges”; and

(II) “Adjusted Gross Total Charges” will be multiplied by the result of part (1)(A)13.C.(I) to yield “Adjusted Net Revenue”;

D. Obtain “Gross Inpatient Charges” from Worksheet G-2, Line 25, Column 1 from CMS 2552-96, or Worksheet G-2, Line 28, Column 1 from CMS 2552-10, of the most recent cost report that is available for a hospital;

E. Obtain “Gross Outpatient Charges” from Worksheet G-2, Line 25, Column 2 from CMS 2552-96, or Worksheet G-2, Line 28, Column 2 from CMS 2552-10, of the most recent cost report that is available for a hospital;

F. Total “Adjusted Net Revenue” will be allocated between “Net Inpatient Revenue” and “Net Outpatient Revenue” as follows:

(I) “Gross Inpatient Charges” will be divided by “Gross Total Charges”;

(II) “Adjusted Net Revenue” will then be multiplied by the result to yield “Net Inpatient Revenue”; and

(III) The remainder will be allocated to “Net Outpatient Revenue”; and

G. The trend indices, if greater than 0%, will be determined based on the Health Care Costs index as published in *Healthcare Cost Review* by Institute of Health Systems (IHS), or equivalent publication, regardless of any changes in the name of the publication or publisher, for each State Fiscal Year (SFY). The trend indices listed below will be applied to the apportioned inpatient adjusted net revenue and outpatient adjusted net revenue in order to inflate or trend forward the adjusted net revenues from the FRA fiscal year cost report to the current state fiscal year to determine the inpatient and outpatient adjusted net revenues subject to the FRA assessment.

(I) SFY 2020 =

(a) Inpatient Adjusted Net Revenues—0%

(b) Outpatient Adjusted Net Revenues—2.9%

(II) SFY 2021 =

(a) Inpatient Adjusted Net Revenues—3.2%

(b) Outpatient Adjusted Net Revenues—0%

(III) SFY 2022 =

(a) Inpatient Adjusted Net Revenues—4.2%

(b) Outpatient Adjusted Net Revenues—0%

(IV) SFY 2023 =

(a) Inpatient Adjusted Net Revenues—3.8%

(b) Outpatient Adjusted Net Revenues—0%

(5) Beginning July 1, 2022, the FRA assessment shall be determined at a rate of five and forty hundredths percent (5.40%) of each hospital’s inpatient adjusted net revenues and outpatient adjusted net revenues as set forth in paragraph (1)(A)13. The FRA assessment rate will be applied individually to the hospital’s inpatient adjusted net revenues and outpatient adjusted net rev-

enues. The hospital’s total FRA assessment is the sum of the assessment determined from its inpatient adjusted net revenue plus the assessment determined for its outpatient adjusted net revenue.

*AUTHORITY: sections 208.201, 208.453, 208.455, and 660.017, RSMo 2016. Emergency rule filed Sept. 21, 1992, effective Oct. 1, 1992, expired Jan. 28, 1993. Emergency rule filed Jan. 15, 1993, effective Jan. 25, 1993, expired May 24, 1993. Original rule filed Sept. 21, 1992, effective June 7, 1993. For intervening history, please consult the Code of State Regulations. Emergency amendment filed June 15, 2022, effective July 1, 2022, expires Feb. 23, 2023. A proposed amendment covering this same material is published in this issue of the Missouri Register.*

*PUBLIC COST: For the 6 months of SFY 2023 that this emergency amendment is effective, this emergency amendment will result in FRA Assessment cost to public entities of approximately \$1.7 million.*

*PRIVATE COST: For the 6 months of SFY 2023 that this emergency amendment is effective, this emergency amendment will result in FRA Assessment cost to private entities of approximately \$10 million.*

**FISCAL NOTE  
PUBLIC COST**

- I. Department Title:** Title 13 - Department of Social Services  
**Division Title:** Division 70 - MO HealthNet Division  
**Chapter Title:** Chapter 15 – Hospital Program

<b>Rule Number and Title:</b>	13 CSR 70-15.110 Federal Reimbursement Allowance (FRA)
<b>Type of Rulemaking:</b>	Emergency Amendment

**II. SUMMARY OF FISCAL IMPACT**

<b>Affected Agency or Political Subdivision</b>	<b>Estimated Cost of Compliance in the Aggregate</b>
<b>Other Government (Public) &amp; State Hospitals - 38</b>	<b>Estimated cost for: SFY 2023 - \$1.7 million</b>

**III. WORKSHEET****Estimated Assessment at 5.40% for SFY 2023:**

	No. of Facilities	Inpatient Revenues	Outpatient Revenues	Total
Public Facilities Revenues	38	\$834,001,448	\$934,487,226	\$1,768,488,674
FRA Assessment Rate		5.40%	5.40%	5.40%
Total Assessment without Trend		\$45,036,078	\$50,462,310	\$95,498,388
Revenue Trend for SFY 2022		3.80%	0.00%	
Total Revenues Trended		\$865,693,503	\$934,487,226	\$1,800,180,729
FRA Assessment Rate		5.40%	5.40%	5.40%
Total Assessment with Trend		\$46,747,449	\$50,462,310	\$97,209,759
Impact of Trend (Assessment with trend less Assessment without trend)				\$1,711,371

#### **IV. ASSUMPTIONS**

This fiscal note reflects the total FRA Assessment of 5.40% for July 1, 2022 through June 30, 2023. The fiscal note is based on establishing the FRA Assessment rate as noted above and a trend of 3.8% on inpatient revenues and 0% on outpatient revenues beginning July 1, 2022. The FRA Assessment rate is levied upon Missouri hospitals' trended inpatient and outpatient net adjusted revenues in accordance with the Missouri Partnership Plan.

**FISCAL NOTE  
PRIVATE COST**

- I. Department Title:** Title 13 - Department of Social Services  
**Division Title:** Division 70 - MO HealthNet Division  
**Chapter Title:** Chapter 15 – Hospital Program

<b>Rule Number and Title:</b>	13 CSR 70-15.110 Federal Reimbursement Allowance (FRA)
<b>Type of Rulemaking:</b>	Emergency Amendment

**II. SUMMARY OF FISCAL IMPACT**

Estimate of the number of entities by class which would likely be affected by the adoption of the proposed rule:	Classification by types of the business entities which would likely be affected:	Estimate in the aggregate as to the cost of compliance with the rule by the affected entities:
100	Hospitals	Estimated cost for: SFY 2023 - \$10 million

**III. WORKSHEET****Estimated Assessment at 5.40% for SFY 2023:**

	No. of Facilities	Inpatient Revenues	Outpatient Revenues	Total
Private Facilities Revenues	100	\$4,891,805,760	\$4,882,574,169	\$9,774,379,929
FRA Assessment Rate		5.40%	5.40%	5.40%
Total Assessment without Trend		\$264,157,511	\$263,659,005	\$527,816,516
Revenue Trend for SFY 2022		3.80%	0.00%	
Total Revenues Trended		\$5,077,694,378	\$4,882,574,169	\$9,960,268,547
FRA Assessment Rate		5.40%	5.40%	5.40%
Total Assessment with Trend		\$274,195,496	\$263,659,005	\$537,854,502
Impact of Trend (Assessment with trend less Assessment without trend)				\$10,037,986



#### **IV. ASSUMPTIONS**

This fiscal note reflects the total FRA Assessment of 5.40% for July 1, 2022 through June 30, 2023. The fiscal note is based on establishing the FRA Assessment rate as noted above and a trend of 3.8% on inpatient revenues and 0% on outpatient revenues beginning July 1, 2022. The FRA Assessment rate is levied upon Missouri hospitals' trended inpatient and outpatient net adjusted revenues in accordance with the Missouri Partnership Plan.

**Title 13—DEPARTMENT OF SOCIAL SERVICES****Division 70—MO HealthNet Division****Chapter 15—Hospital Program****EMERGENCY AMENDMENT****13 CSR 70-15.160 Outpatient Hospital Services Reimbursement Methodology.** The division is amending section (5).

*PURPOSE:* This emergency amendment updates all documents incorporated by reference and used to create the outpatient simplified fee schedule.

*EMERGENCY STATEMENT:* The Department of Social Services, MO HealthNet Division (MHD) finds that this emergency amendment is necessary to preserve a compelling governmental interest as it allows MHD to continue to pay its hospital providers under a financially sustainable payment methodology. The Outpatient Simplified Fee Schedule (OSFS) payment methodology requires the most recent fee schedules published by Centers for Medicare & Medicaid Services (CMS) to be incorporated by reference to compute the OSFS fee schedule, which allows providers to be paid. Since the dates on which CMS updates its fee schedules vary throughout the year, an emergency amendment is necessary in order to maintain a correct fee schedule by July 1 of each year. This emergency amendment is necessary to incorporate the most recently published fee schedules into the methodology to comply with the regulation. Furthermore, this emergency amendment is necessary to secure a sustainable Medicaid program in Missouri, and ensure that payments for outpatient services are in line with funds appropriated for that purpose. (See *Beverly Enterprises-Missouri Inc. v. Dept of Soc. Servs., Div. of Med. Servs.*, 349 S.W.3d 337, 350 (Mo. Ct. App. 2008)) As a result, MHD finds a compelling governmental interest, which requires this emergency action. A proposed amendment, which covers the same material, is published in this issue of the *Missouri Register*. This emergency amendment limits its scope to the circumstances creating the emergency and complies with the protections extended by the *Missouri and United States Constitutions*. The MHD believes this emergency amendment to be fair to all interested parties under the circumstances. This emergency amendment was filed June 13, 2022, becomes effective July 1, 2022, and expires February 23, 2023.

**(5) Outpatient Simplified Fee Schedule (OSFS) Payment Methodology.**

(A) Definitions. The following definitions will be used in administering section (5) of this rule:

1. Ambulatory Payment Classification (APC). Medicare's ambulatory payment classification assignment groups of Current Procedural Terminology (CPT) or Healthcare Common Procedures Coding System (HCPCS) codes. APCs classify and group clinically similar outpatient hospital services that can be expected to consume similar amounts of hospital resources. All services within an APC group have the same relative weight used to calculate the payment rates;

2. APC conversion factor. The unadjusted national conversion factor calculated by Medicare effective January 1 of each year, as published with the Medicare Outpatient Prospective Payment System (OPPS) Final Rule, and used to convert the APC relative weights into a dollar payment. The Medicare OPPS Final Rule is incorporated by reference and made a part of this rule as published by the *[Department of Social Services, MO HealthNet Division, 615 Howerton Court, Jefferson City, MO 65109, at its website] Centers for Medicare & Medicaid Services, 7500 Security Boulevard, Baltimore, MD 21244, and available at <https://www.govinfo.gov/content/pkg/FR-2021-11-16/pdf/2021-24011.pdf>, [December 9, 2020] November 19, 2021. This rule does not incorporate any subsequent amendments or additions;*

3. APC relative weight. The national relative weights calculated by Medicare for the Outpatient Prospective Payment System;

4. Current Procedural Terminology (CPT). A medical code set that is used to report medical, surgical, and diagnostic procedures and services to entities such as physicians, health insurance companies, and accreditation organizations;

5. Dental procedure codes. The procedure codes found in the Code on Dental Procedures and Nomenclature (CDT), a national uniform coding method for dental procedures maintained by the American Dental Association;

6. Federally-Deemed Critical Access Hospital. Hospitals that meet the federal definition found in section 1820(c)(2)(B) of the Social Security Act;

7. HCPCS. The national uniform coding method maintained by the Centers for Medicare [and] & Medicaid Services (CMS) that incorporates the American Medical Association (AMA) Physicians CPT and the three (3) HCPCS unique coding levels, I, II, and III;

8. Medicare Inpatient Prospective Payment System (IPPS) wage index. The wage area index values are calculated annually by Medicare, published as part of the Medicare IPPS Final Rule;

9. Missouri conversion factor. The single, statewide conversion factor used by the MO HealthNet Division (MHD) to determine the APC-based fees, uses a formula based on Medicare OPPS. The formula consists of: sixty percent (60%) of the APC conversion factor, as defined in paragraph (5)(A)2. multiplied by the St. Louis, MO Medicare IPPS wage index value, plus the remaining forty percent (40%) of the APC conversion factor, with no wage index adjustment;

10. Nominal charge provider. A nominal charge provider is determined from the [fourth] third prior year audited Medicaid cost report. The hospital must meet the following criteria:

A. A public non-state governmental acute care hospital with a low income utilization rate (LIUR) of at least [fifty percent (50%)] **forty percent (40%)** and a Medicaid inpatient utilization rate (MIUR) greater than one (1) standard deviation from the mean, and is licensed for fifty (50) inpatient beds or more and has an occupancy rate of at least forty percent (40%). The hospital must meet one (1) of the federally mandated Disproportionate Share qualifications; or

B. The hospital is a public hospital operated by the Department of Mental Health primarily for the care and treatment of mental disorders; and

C. A hospital physically located in the State of Missouri;

11. Outpatient Prospective Payment System (OPPS). Medicare's hospital outpatient prospective payment system mandated by the Balanced Budget Refinement Act of 1999 (BBRA) and the Medicare, Medicaid, and State Children's Health Insurance Program (SCHIP) Benefits Improvement and Protection Act (BIPA) of 2000; and

12. Payment level adjustment. The percentage applied to the Medicare fee to derive the OSFS fee.

(B) Effective for dates of service beginning July 20, 2021, outpatient hospital services shall be reimbursed on a predetermined fee-for-service basis using an OSFS based on the APC groups and fees under the Medicare Hospital OPPS. When service coverage and payment policy differences exist between Medicare OPPS and Medicaid, MHD policies and fee schedules are used. The fee schedule will be updated as follows:

1. MHD will review and adjust the OSFS annually on July 1 based on the payment method described in subsection (5)(D); and

2. The OSFS is incorporated by reference and made a part of this rule as published by the Department of Social Services, MO HealthNet Division, 615 Howerton Court, Jefferson City, MO 65109, at its website at [<https://dssruletracker.mo.gov/dss-proposed-rules/welcome.action>, July 20, 2021.] <https://dss.mo.gov/mhd/providers/fee-for-service-providers.htm>, **June 15, 2022**. This rule does not incorporate any subsequent amendments or additions.

(C) Payment will be the lower of the provider's charge or the payment as calculated in subsection (5)(D).

(D) Fee schedule methodology. Fees for outpatient hospital services covered by the MO HealthNet program are determined by the

HCPCS procedure code at the line level and the following hierarchy:

1. The APC relative weight or payment rate assigned to the procedure in the Medicare OPPS *Addendum B* is used to calculate the fee for the service, with the exception of the hospital observation per hour fee which is calculated based on the method described in subparagraph (5)(D)1.B. Fees derived from APC weights and payment rates are established using the Medicare OPPS *Addendum B* effective as of January 1 of each year as published by the CMS for Medicare OPPS. The Medicare OPPS *Addendum B* is incorporated by reference and made a part of this rule as published by the [Department of Social Services, MO HealthNet Division, 615 Howerton Court, Jefferson City, MO 65109, at its website at] Centers for Medicare & Medicaid Services, 7500 Security Boulevard, Baltimore, MD 21244, and available at [<https://dssruletracker.mo.gov/dss-proposed-rules/welcome.action>, December 29, 2020] <https://www.cms.gov/medicare/medicare-fee-service-payment/hospitaloutpatientppsaddendum-and-addendum-b-updates/january-2022-0>, January 18, 2022. This rule does not incorporate any subsequent amendments or additions.

A. The fee is calculated using the APC relative weight times the Missouri conversion factor. The resulting amount is then multiplied by the payment level adjustment of ninety percent (90%) to derive the OSFS fee.

B. The hourly fee for observation is calculated based on the relative weight for the Medicare APC (using the Medicare OPPS *Addendum A* effective as of January 1 of each year as published by the CMS for Medicare OPPS) which corresponds with comprehensive observation services multiplied by the Missouri conversion factor divided by forty (40), the maximum payable hours by Medicare. The resulting amount is then multiplied by the payment level adjustment of ninety percent (90%) to derive the OSFS fee. The Medicare OPPS *Addendum A* is incorporated by reference and made a part of this rule as published by the Centers for Medicare [and] & Medicaid Services, 7500 Security Boulevard, Baltimore, MD 21244, and available at [<https://dssruletracker.mo.gov/dss-proposed-rules/welcome.action>, July 6, 2021] <https://www.cms.gov/medicare/medicare-fee-service-payment/hospitaloutpatientppsaddendum-and-addendum-b-updates/january-2022>, January 18, 2022. This rule does not incorporate any subsequent amendments or additions.

C. For those APCs with no assigned relative weight, ninety percent (90%) of the Medicare APC payment rate is used as the fee;

2. If there is no APC relative weight or APC payment rate established for a particular service in the Medicare OPPS *Addendum B*, then the MHD approved fee will be ninety percent (90%) of the rate listed on other Medicare fee schedules, effective as of January 1 of each year: Clinical Laboratory Fee Schedule; Physician Fee Schedule; and Durable Medical Equipment Prosthetics/Orthotics and Supplies Fee Schedule, applicable to the outpatient hospital service.

A. The Medicare *Clinical Laboratory Fee Schedule* is incorporated by reference and made a part of this rule as published by the Centers for Medicare [and] & Medicaid Services, 7500 Security Boulevard, Baltimore, MD 21244, and available at [<https://www.cms.gov/license/ama?file=/files/zip/21clabq1.zip>, January 5, 2021] <https://www.cms.gov/medicare/medicare-fee-service-payment/clinicallabfeesched/clinical-laboratory-fee-schedule-files/22clabq1>, December 29, 2021. This rule does not incorporate any subsequent amendments or additions.

B. The Medicare *Physician Fee Schedule* is incorporated by reference and made a part of this rule as published by the Centers for Medicare [and] & Medicaid Services, 7500 Security Boulevard, Baltimore, MD 21244, and available at [<https://www.cms.gov/medicare/medicare-fee-service-payment/physicianfeesched/pfs-carrier-specific-files/all-states-0> January 4, 2021,] <https://www.cms.gov/medicare/medicare-fee-service-payment/physicianfeesched/pfs-carrier-specific-files/all-states-1>, December 18, 2021. This rule does not incorporate any

subsequent amendments or additions.

C. The Medicare *Durable Medical Equipment Prosthetics/Orthotics and Supplies Fee Schedule* is incorporated by reference and made a part of this rule as published by the Centers for Medicare [and] & Medicaid Services, 7500 Security Boulevard, Baltimore, MD 21244, and available at [<https://www.cms.gov/medicare/medicare-fee-service-payment/dmeposfeesched/dmepos-fee-schedule/dme21>, December 2, 2020] <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/DMEPOSFeeSched/DMEPOS-Fee-Schedule>, December 15, 2021. This rule does not incorporate any subsequent amendments or additions;

3. Fees for dental procedure codes in the outpatient hospital setting are calculated based on thirty-eight and one half percent (38.5%) of the fiftieth percentile fee for Missouri reflected in the [2021] 2022 *National Dental Advisory Service* (NDAS). The [2021] 2022 NDAS is incorporated by reference and made a part of this rule as published by Wasserman Medical & Dental at its website at <https://wasserman-medical.com/product-category/dental/ndas/>, and available at the MO HealthNet Division, 615 Howerton Court, Jefferson, City MO 65109, [April 20, 2021] January 31, 2022. This rule does not incorporate any subsequent amendments or additions;

4. If there is no APC relative weight, APC payment rate, other Medicare fee schedule rate, or NDAS rate established for a covered outpatient hospital service, then a MO HealthNet fee will be determined using the MHD *Dental, Medical, Other Medical or Independent Lab—Technical Component* fee schedules.

A. The MHD *Dental Fee Schedule* is incorporated by reference and made a part of this rule as published by the Department of Social Services, MO HealthNet Division, 615 Howerton Court, Jefferson City, MO 65109, [at its website at <https://dss.mo.gov/mhd/providers/pages/cptagree.htm>, April 12, 2021] and available at : <https://dss.mo.gov/mhd/providers/pages/cptagree.htm>, June 7, 2022. This rule does not incorporate any subsequent amendments or additions.

B. The MHD *Medical Fee Schedule* is incorporated by reference and made a part of this rule as published by the Department of Social Services, MO HealthNet Division, 615 Howerton Court, Jefferson City, MO 65109, [at its website at <https://dssruletracker.mo.gov/dss-proposed-rules/welcome.action>, July 13, 2021] and available at : <https://dss.mo.gov/mhd/providers/pages/cptagree.htm>, June 7, 2022. This rule does not incorporate any subsequent amendments or additions.

C. The MHD *Other Medical Fee Schedule* is incorporated by reference and made a part of this rule as published by the Department of Social Services, MO HealthNet Division, 615 Howerton Court, Jefferson City, MO 65109, [at its website at <https://dss.mo.gov/mhd/providers/pages/cptagree.htm>, April 12, 2021] and available at : <https://dss.mo.gov/mhd/providers/pages/cptagree.htm>, June 7, 2022. This rule does not incorporate any subsequent amendments or additions.

D. The MHD *Independent Lab—Technical Component Fee Schedule* is incorporated by reference and made a part of this rule as published by the Department of Social Services, MO HealthNet Division, 615 Howerton Court, Jefferson City, MO 65109, [at its website at <https://dss.mo.gov/mhd/providers/pages/cptagree.htm>, April 12, 2021] and available at <https://dss.mo.gov/mhd/providers/pages/cptagree.htm>, June 7, 2022. This rule does not incorporate any subsequent amendments or additions;

5. In-state federally-deemed critical access hospitals will receive an additional forty percent (40%) of the rate as determined in paragraph (5)(B)2. for each billed procedure code; and

6. Nominal charge providers will receive an additional twenty-five percent (25%) of the rate as determined in paragraph (5)(B)2. for each billed procedure code.

(E) Packaged services. MHD adopts Medicare guidelines for procedure codes identified as “Items and Services Packaged into APC Rates” under Medicare OPPS *Addendum D1*. These procedures are designated as always packaged. Claim lines with packaged procedure codes will be considered paid but with a payment of zero (0). The Medicare OPPS *Addendum D1* is incorporated by reference and made a part of this rule as published by the Centers for Medicare [and] Medicaid Services, 7500 Security Boulevard, Baltimore, MD 21244, and available at [[https://www.cms.gov/medicare/medicare-fee-for-service-payment/hospitaloutpatientpps/downloads/cms1392fc\\_addendum\\_d1.pdf](https://www.cms.gov/medicare/medicare-fee-for-service-payment/hospitaloutpatientpps/downloads/cms1392fc_addendum_d1.pdf), December 29, 2020] [<https://www.cms.gov/license/ama?file=/files/zip/2022-nfrm-ops-addenda.zip>, November 3, 2021]. This rule does not incorporate any subsequent amendments or additions.

(F) Inpatient only services. MHD adopts Medicare guidelines for procedure codes identified as “Inpatient Procedures” under Medicare OPPS *Addendum D1*. These procedures are designated as inpatient only (referred to as the inpatient only (IPO) list). Claim lines with inpatient only procedures will not be paid under the OSFS.

(G) Drugs. Effective for dates of service beginning April 1, 2019, outpatient drugs are reimbursed in accordance with the methodology described in 13 CSR 70-20.070.

(H) Payment for outpatient hospital services under this rule will be final, with no cost settlement.

*AUTHORITY: sections 208.153, 208.201, and 660.017, RSMo 2016, and section 208.152, RSMo Supp. 2021. Emergency rule filed June 20, 2002, effective July 1, 2002, expired Feb. 27, 2003. Original rule filed June 14, 2002, effective Jan. 30, 2003. For intervening history, please consult the **Code of State Regulations**. Emergency amendment filed June 13, 2022, effective July 1, 2022, expires Feb. 23, 2022. A proposed amendment covering this same material is published in this issue of the **Missouri Register**.*

*PUBLIC COST: This emergency amendment is estimated to cost the Department of Social Services \$5,618,290.00 during the time the emergency amendment is effective. This emergency amendment will not cost state agencies or political subdivisions, other than the Department of Social Services, more than five hundred dollars (\$500) in the aggregate during the time the emergency is effective.*

*PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars (\$500) in the aggregate during the time the emergency amendment is effective.*

**FISCAL NOTE  
PUBLIC COST**

- I. Department Title:** Title 13 - Department of Social Services  
**Division Title:** Division 70 - MO HealthNet Division  
**Chapter Title:** Chapter 15 – Hospital Program

<b>Rule Number and Title:</b>	13 CSR 70-15.160 Outpatient Hospital Services Reimbursement Methodology
<b>Type of Rulemaking:</b>	Emergency Amendment

**II. SUMMARY OF FISCAL IMPACT**

Affected Agency or Political Subdivision	Estimated Cost of Compliance in the Aggregate
<b>Other Government (Public) &amp; State Hospitals enrolled in MO HealthNet - 32</b>  <b>Department of Social Services, MO HealthNet Division</b>	<b>No Fiscal Impact</b>  <b>SFY 2023 Impact (6 Months):</b> <b>Total Costs is estimated at \$5.6 million;</b> <b>State Share is estimated at \$1.9 million</b>

**III. WORKSHEET**

<b>Department of Social Services, MO HealthNet Division Savings:</b>	
<b><u>Estimated Costs for 6 Months of SFY 2023:</u></b>	
Estimated Costs	\$5,618,289
Times FFY 2022 State Share Percentage	33.64%
Estimated State Share Savings	\$1,889,992

The state estimates that there is not a cost to other government (public) and state hospitals. The state anticipates an increase in payments in aggregate of \$1.7 million.

**IV. ASSUMPTIONS**

The estimated cost is due to Medicare increasing their rates for the following high volume services: emergency department visits, clinic visits, and some laboratory services.

**Title 13—DEPARTMENT OF SOCIAL SERVICES**  
**Division 70—MO HealthNet Division**  
**Chapter 15—Hospital Program**

**EMERGENCY AMENDMENT**

**13 CSR 70-15.230 [Supplemental] Upper Payment Limit (UPL) Payment Methodology.** The division is amending the title and section (2).

*PURPOSE:* This emergency amendment establishes a methodology for determining Upper Payment Limit (UPL) payments provided to State Government owned hospitals beginning July 1, 2022.

*EMERGENCY STATEMENT:* This emergency amendment allows the Department of Social Services, MO HealthNet Division (MHD) to make Upper Payment Limit (UPL) Payments to only State Government owned hospitals. This emergency amendment is necessary to preserve a compelling governmental interest as it allows the State Medicaid Agency to pay State Government owned hospitals a supplemental payment to cover the costs of Medicaid services provided to Missouri participants. As a result, the MHD finds a compelling governmental interest in providing these payments to State Government owned hospitals by July 1, 2022, which requires an early effective date. A proposed amendment, which covers the same material, is published in this issue of the *Missouri Register*. The scope of this emergency amendment is limited to the circumstances creating the emergency and complies with the protections extended by the *Missouri* and *United States Constitutions*. The MHD believes this emergency amendment to be fair to all interested parties under the circumstances. This emergency amendment was filed June 14, 2022, becomes effective July 1, 2022, and expires February 23, 2023.

(2) [Beginning with State Fiscal Year 2012, each participating hospital may be paid supplemental payments up to the Medicare Upper Payment Limit (UPL).] Beginning with SFY 2023, State Government owned hospitals will be paid a semi-monthly payment up to the inpatient (IP) UPL gap.

(A) [UPL Payment. Supplemental payments may be paid to qualifying hospitals for inpatient services. The total amount of supplemental payments made under this section in each year shall not exceed the Medicare Upper Payment Limit, after accounting for all other supplemental payments. Payments under this section will be determined prior to the determination of payments under subsection (2)(B) below authorizing Medicaid UPL Supplemental Payments for Low Income and Needy Care Collaboration hospitals.] Prior to each SFY, the Division shall calculate the estimated Medicaid payments for the coming SFY for each hospital. The total estimated Medicaid payments for each hospital shall be subtracted from the hospital's IP UPL calculated in accordance to the methodology set forth below then summed to calculate the IP UPL gap. The IP UPL gap is reduced by the estimated inpatient fee-for-service Graduate Medical Education (GME) payments for the coming SFY for each hospital to calculate the total amount of funding available. The available IP UPL gap is distributed to each hospital based on the hospital's percent of estimated Medicaid payments for the coming SFY to total estimated payments for the coming SFY for all state government owned hospitals. The available gap under the IP UPL for each eligible hospital will be aggregated to create the supplemental payment amount. The total calculated supplemental payment amount will be paid to eligible hospitals.

1. [The state shall determine the amount of Medicaid supplemental payments payable under this section on an annual basis. The state shall calculate the Medicare Upper Payment Limit for each of the three (3) categories of hospi-

tals: state hospitals, non-state governmental hospitals, and private hospitals. The state shall apportion the Medicaid supplemental payments payable under this section to each of the three (3) categories of hospitals based on the proportionate Medicare Upper Payment Limits for each category of hospitals.] The IP UPL will be determined based on the hospital's Medicaid inpatient costs using Medicare cost reporting principles. All Medicare cost report worksheet, column, or line references are based upon the Medicare Cost Report (MCR) CMS 2552-10 and should be adjusted for any CMS approved successor MCR. The amount that Medicare would pay shall be calculated as follows:

A. Using Medicare cost report data within the previous two years of the IP UPL demonstration dates in accordance with IP UPL guidelines set by CMS, Total Medicare Costs shall be derived from the reported Inpatient Hospital Cost on the following cost report variable locations:

(I) Worksheet D-1, Hospital/IPF/IRF Components, Column 1, Line 49

(II) Plus Organ Acquisitions Cost from all applicable Worksheets D-4, Column 1, Line 69

(III) Plus GME Aggregated Approved Amount from Worksheet E-4, Column 1, Line 49

B. Total Medicare Patient Days shall be derived from Worksheet S-3, Part I, Column 6, Lines 14, 16, and 17 of the same cost report as the Total Medicare Costs.

C. A calculated Medicare Cost Per Diem shall be calculated by dividing the Total Medicare Costs by the hospital's Total Medicare Patient Days.

D. The calculated Medicare Cost Per Diem shall be multiplied by the total Medicaid Patient Days from a twelve (12) month data set from the prior two (2) years of the IP UPL demonstration dates in accordance with the IP UPL guidelines set by CMS to derive the hospital's IP UPL.

(I) The data source for the Medicaid Patient Days and Total Medicaid Payments shall be from the state's MMIS claims data.

E. The calculated IP UPL shall be inflated from the midpoint of the hospital's cost report period to the midpoint of the IP UPL demonstration period using the CMS PPS hospital market basket index.

F. If payments in this section would result in payments to any category of hospitals in excess of the IP UPL calculation required by 42 C.F.R 447.272, payments for each eligible hospital receiving payments under this section will be reduced proportionately to ensure compliance with the IP UPL.

[2. Each participating hospital may be paid its proportional share of the UPL gap based upon its Medicaid inpatient utilization.

(B) Supplemental Payments for Low Income and Needy Care Collaboration Hospitals. Additional Supplemental Payments for Low Income and Needy Collaboration Hospitals may be made if there is room remaining under the UPL to make additional payments without exceeding the UPL, after making the UPL payments in subsection (2)(A) above.

1. Effective for dates of services on or after July 1, 2011, supplemental payments may be issued to qualifying hospitals for inpatient services after July 1, 2011. Maximum aggregate payments to all qualifying hospitals under this section shall not exceed the available Medicare Upper Payment Limit, less all other Medicaid inpatient payments to private hospitals under this State Plan which are subject to the Medicaid Upper Payment Limit.

2. Qualifying criteria. In order to qualify for the supplemental payment under this section, the private hospital must be affiliated with a state or local governmental entity through a Low Income and Needy Care Collaboration Agreement. The state or local governmental entity includes

*governmentally-supported hospitals.*

*A. A private hospital is defined as a hospital that is owned or operated by a private entity.*

*B. A Low Income and Needy Care Collaboration Agreement is defined as an agreement between a private hospital and a state or local governmental entity to collaborate for purposes of providing healthcare services to low income and needy patients.*

*C. Reimbursement methodology. Each qualifying private hospital may be eligible to receive supplemental payments. The total supplemental payments in any fiscal year will not exceed the lesser of—*

*(I) The difference between each qualifying hospital's inpatient Medicaid billed charges and Medicaid payment the hospital receives for covered inpatient services for Medicaid participants during the fiscal year; or*

*(II) For hospitals participating in the Medicaid Disproportionate Share Hospital (DSH) program, the difference between the hospital's specific DSH cap and the hospital's DSH payments during the fiscal year.*

*D. Payments under this section will be determined after the determination of payments under subsection (2)(A) above authorizing Medicaid UPL supplemental payments.]*

*AUTHORITY: sections [208.152,] 208.153, [and] 208.201, and 660.017, RSMo 2016, and section 208.152, RSMo Supp. [2010] 2021. Emergency rule filed May 20, 2011, effective July 1, 2011, expired Dec. 28, 2011. Original rule filed May 20, 2011, effective Jan. 30, 2012. Emergency amendment filed June 14, 2022, effective July 1, 2022, expires Feb. 23, 2023. A proposed amendment covering this same material is published in this issue of the **Missouri Register**.*

*PUBLIC COST: This emergency amendment is estimated to cost the state approximately \$12.5 million (State Share: \$3.7 million FRA and \$566 thousand IGT for DMH) in the time the emergency is effective. This emergency amendment is estimated to increase payments to state entities by approximately \$12.5 million in the time the emergency is effective.*

*PRIVATE COST: This emergency amendment will not cost private entities more than five hundred dollars (\$500) in the time the emergency is effective.*

**FISCAL NOTE  
PUBLIC COST**

- I. **Department Title:** 13 Social Services  
**Division Title:** 70 MO HealthNet Division  
**Chapter Title:** 15 Hospital Program

<b>Rule Number and Name:</b>	13 CSR 70-15.230 Upper Payment Limit (UPL) Payment Methodology
<b>Type of Rulemaking:</b>	Emergency Amendment

**II. SUMMARY OF FISCAL IMPACT**

Affected Agency or Political Subdivision	Estimated Cost of Compliance in the Aggregate
State Hospitals enrolled in MO HealthNet - 6	Estimated impact for 6 months of SFY 2023: \$12.5 million
Department of Social Services, MO HealthNet Division	Estimated cost for 6 months of SFY 2023: Total \$12.5 million; State Share \$3.7 million (FRA) State Share \$566 thousand (IGT)

**III. WORKSHEET**

<b>Other Government (Public) &amp; State Hospitals Impact:</b>			
<b>Estimated Cost for 6 Months of SFY 2023:</b>			
	FRA Fund	IGT Fund	Total
Estimated Impact to State Hospitals	\$10,788,980	\$1,661,580	\$12,450,560
Estimated Impact to Other Government (Public) Hospitals	\$0	\$0	\$0
Total Estimated Impact	\$10,788,980	\$1,661,580	\$12,450,560
State Share Percentage	34.0525%	34.0525%	34.0525%
Estimated State Share	\$3,673,917	\$565,810	\$4,239,727
<b>Department of Social Services, MO HealthNet Division Cost:</b>			
<b>Estimated Cost for 6 Months of SFY 2023:</b>			
	FRA Fund	IGT Fund	Total
Estimated Cost	\$10,788,980	\$1,661,580	\$12,450,560
State Share Percentage	34.0525%	34.0525%	34.0525%
Estimated State Share Cost	\$3,673,917	\$565,810	\$4,239,727



#### **IV. ASSUMPTIONS**

The following regulations are impacted by the change to the hospital reimbursement methodology and the impact of all the regulations should be netted to arrive at the total impact. The net impact is a cost to the state of \$3.8 million for 6 months of SFY 2023.

13 CSR 70-15.010  
13 CSR 70-15.015  
13 CSR 70-15.220  
13 CSR 70-15.230

The fiscal impact is estimated based on historical utilization and enrollment. Other variables such as the length of the Federal Public Health Emergency and Medicaid Expansion enrollment may indirectly affect the hospital utilization both positively and negatively. Due to the uncertainty of these variables, the state will continue to monitor the impacts to the Managed Care Organizations and hospitals.

**FISCAL NOTE  
PRIVATE COST**

- I. Department Title:** 13 Social Services  
**Division Title:** 70 MO HealthNet Division  
**Chapter Title:** 15 Hospital Program

<b>Rule Number and Title:</b>	13 CSR 70-15.230 Upper Payment Limit (UPL) Payment Methodology
<b>Type of Rulemaking:</b>	Emergency Amendment

**II. SUMMARY OF FISCAL IMPACT**

<b>Estimate of the number of entities by class which would likely be affected by the adoption of the rule:</b>	<b>Classification by types of the business entities which would likely be affected:</b>	<b>Estimate in the aggregate as to the cost of compliance with the rule by the affected entities:</b>
In-State Hospitals – 0	Private Hospitals enrolled in MO HealthNet	Estimated impact for 6 months of SFY 2023: \$0 million

**III. WORKSHEET**

N/A

**IV. ASSUMPTIONS**

There is no estimated impact to in-state private hospitals since this regulation is only for payments made to state owned or operated hospitals.

**Title 20—DEPARTMENT OF COMMERCE AND  
INSURANCE**

**Division 2220—State Board of Pharmacy  
Chapter 2—General Rules**

**EMERGENCY AMENDMENT**

**20 CSR 2220-2.400 Compounding Standards of Practice.** The board is adding subsection (12)(A).

*PURPOSE:* This emergency amendment allows compounding of iodinated contrast media prior to receiving a patient specific prescription until December 17, 2022, to address a national supply shortage.

*EMERGENCY STATEMENT:* On May 9, 2022, the U.S. Food and Drug Administration announced a national shortage of iohexol injection stemming from the temporary shutdown of the manufacturer's production facility in Shanghai, China, reportedly related to COVID-19. Iohexol injection is an iodinated contrast media used, in part, to provide emergency medical care to patients suffering from possible strokes, heart attacks, abdominal pain, and pulmonary embolisms. Iodinated contrast media is also used for computerized tomography (CT) scans and by oncology practices. The Missouri Hospital Association (MHA) and a large Missouri hospital system subsequently met with board staff on June 1, 2022, and asked that the board take emergency action to allow pharmacies to repackage/compound currently available iodinated contrast media in smaller quantities for use by other hospitals, ambulatory surgical centers, pharmacies, and healthcare entities. Absent emergency action, MHA indicated Missouri hospitals and healthcare providers may not have adequate supply of iodinated contrast media to treat critical Missouri patients. Significantly, multiple Missouri pharmacies and hospitals reported needed imaging contrast is unavailable from other manufacturers, with some Missouri hospitals reporting up to an eighty percent (80%) decrease in allocations/available quantities. The manufacturer has reopened production on a limited basis, however, iodinated contrast media shortages are anticipated to last through the fall, at a minimum. As a result, the Missouri Board of Pharmacy finds there is an immediate danger to the public health, safety and/or welfare and a compelling governmental interest that requires this emergency action. Specifically, the emergency amendment would allow pharmacies to repackage/compound iodinated contrast media for use by other hospitals, pharmacies, and healthcare entities until December 17, 2022. Absent an emergency rule, Missouri patients may not be able to receive critical lifesaving care/treatment. The scope of this emergency amendment is limited to the circumstances creating the emergency and complies with the protections extended in the *Missouri and United States Constitutions*. The Missouri Board of Pharmacy believe this emergency amendment is fair to all interested persons and parties under the circumstances. This emergency amendment was filed June 6, 2022, becomes effective June 21, 2022, and expires December 17, 2022.

(12) Except as provided by law, pharmacists shall not offer or provide compounded preparations to other pharmacies, practitioners, or entities for subsequent dispensing, distribution, resale, or administration, except in the course of professional practice for a prescriber to administer to an individual patient by a prescription dispensed by the pharmacy. A pharmacist or pharmacy may advertise or otherwise provide information concerning the provision of compounding services; however, no pharmacist or pharmacy shall attempt to solicit business by making specific claims about compounded preparations.

(A) Due to a national shortage, a pharmacist may compound and provide iodinated contrast media to/for other pharmacies, practitioners, or entities without a patient specific prescription/order for dispensing or administration if the medication is compounded in a Class H Sterile Compounding Pharmacy in compliance with 20 CSR 2220-2.200. The provisions of this subsection (12)(A)

shall expire on December 17, 2022.

*AUTHORITY:* sections 338.010 and 338.140, RSMo Supp. [2018] 2021, and sections [338.140,] 338.240[,] and 338.280, RSMo 2016. This rule originally filed as 4 CSR 220-2.400. Original rule filed Aug. 25, 1995, effective April 30, 1996. For intervening history, please consult the *Code of State Regulations*. Emergency amendment filed June 6, 2022, effective June 21, 2022, expires Dec. 17, 2022.

*PUBLIC COST:* This emergency amendment will not cost state agencies or political subdivisions more than five hundred dollars (\$500) in the time the emergency is effective.

*PRIVATE COST:* This emergency amendment will not cost private entities more than five hundred dollars (\$500) in the time the emergency is effective.

**U**nder this heading will appear the text of proposed rules and changes. The notice of proposed rulemaking is required to contain an explanation of any new rule or any change in an existing rule and the reasons therefor. This is set out in the Purpose section with each rule. Also required is a citation to the legal authority to make rules. This appears following the text of the rule, after the word "Authority."

**E**ntirely new rules are printed without any special symbolology under the heading of proposed rule. If an existing rule is to be amended or rescinded, it will have a heading of proposed amendment or proposed rescission. Rules which are proposed to be amended will have new matter printed in boldface type and matter to be deleted placed in brackets.

**A**n important function of the *Missouri Register* is to solicit and encourage public participation in the rulemaking process. The law provides that for every proposed rule, amendment, or rescission there must be a notice that anyone may comment on the proposed action. This comment may take different forms.

**I**f an agency is required by statute to hold a public hearing before making any new rules, then a Notice of Public Hearing will appear following the text of the rule. Hearing dates must be at least thirty (30) days after publication of the notice in the *Missouri Register*. If no hearing is planned or required, the agency must give a Notice to Submit Comments. This allows anyone to file statements in support of or in opposition to the proposed action with the agency within a specified time, no less than thirty (30) days after publication of the notice in the *Missouri Register*.

**A**n agency may hold a public hearing on a rule even though not required by law to hold one. If an agency allows comments to be received following the hearing date, the close of comments date will be used as the beginning day in the ninety- (90-) day-count necessary for the filing of the order of rulemaking.

**I**f an agency decides to hold a public hearing after planning not to, it must withdraw the earlier notice and file a new notice of proposed rulemaking and schedule a hearing for a date not less than thirty (30) days from the date of publication of the new notice.

Proposed Amendment Text Reminder:

**Boldface text indicates new matter.**

[Bracketed text indicates matter being deleted.]

## Title 2—DEPARTMENT OF AGRICULTURE Division 80—State Milk Board Chapter 2—Grade "A" Pasteurized Milk Regulations

### PROPOSED AMENDMENT

**2 CSR 80-2.190 State Milk Board Grade "A" Milk Policies.** The board is amending subsection (11)(A).

*PURPOSE: This proposed amendment updates the required farm bulk milk tank pick-up to be consistent with the **Grade "A" Pasteurized Milk Ordinance (PMO)**, 2019 Revision of the United States Department of Health and Human Services, Public Health Service, Food and Drug Administration.*

(11) Farm Bulk Milk Collections.

(A) Farm bulk milk collections shall be made at least once every [forty-eight (48) hours or every other day] **seventy-two (72)**

**hours or every third day.** Extended pickups may be granted by individual request to the executive secretary of the State Milk Board provided the safety and quality of milk is maintained and the delayed collection does not extend beyond the limit allowed by law. In the event of a natural disaster or emergency limiting milk pickups beyond the control of the hauler or producer, this regulation may be waived across specified geographic regions as needed.

*AUTHORITY: section 196.939, RSMo 2016. Original rule filed June 21, 2011, effective Dec. 30, 2011. Amended: Filed April 30, 2018, effective Nov. 30, 2018. Amended: Filed Sept. 4, 2020, effective March 30, 2021. Amended: Filed June 3, 2022.*

*PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars (\$500) in the aggregate.*

*PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars (\$500) in the aggregate.*

*NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the State Milk Board, 1616 Missouri Boulevard, Jefferson City, MO 65109. To be considered, comments must be received within thirty (30) days after publication of this notice in the **Missouri Register**. A public hearing is scheduled for August 15, 2022, from 10:00–11:00 am at Missouri Department of Agriculture, 1616 Missouri Boulevard, Jefferson City, MO 65109 in State Milk Board Office.*

## Title 2—DEPARTMENT OF AGRICULTURE Division 80—State Milk Board Chapter 5—Inspections

### PROPOSED AMENDMENT

**2 CSR 80-5.010 Inspection Fees.** The board is amending the purpose and section (1).

*PURPOSE: This amendment sets the inspection fees for the 2023 Fiscal Year.*

*PURPOSE: This rule complies with section 196.945, RSMo[.], to set inspection fees for Fiscal Year [2022] **2023** for milk produced on farms inspected by State Milk Board and milk imported from points beyond the limits of routine inspection.*

(1) The inspection fee for Fiscal Year [2022] **2023** (July 1, [2021] 2022–June 30, [2022] **2023**) shall be four and a quarter cents (4.25¢) per hundred weight on milk produced on farms inspected by the State Milk Board or its contracted local authority and four cents (4¢) per hundred weight on milk imported from areas beyond the points of routine inspection.

*AUTHORITY: section 196.939, RSMo 2016. Original rule filed April 12, 1977, effective Sept. 11, 1977. For intervening history, please consult the **Code of State Regulations**. Amended: Filed June 3, 2022.*

*PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars (\$500) in the aggregate.*

*PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars (\$500) in the aggregate.*

*NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in*

support of or in opposition to this proposed amendment with the Missouri Department of Agriculture, Amy Luecke, PO Box 630, Jefferson City, MO 65102 or by email to amy.luecke@mda.mo.gov. To be considered, comments must be received within thirty (30) days after publication of this notice in the *Missouri Register*. No public hearing is scheduled.

**Title 7—MISSOURI DEPARTMENT OF  
TRANSPORTATION  
Division 10—Missouri Highways and Transportation  
Commission  
Chapter 1—Organization; General Provisions**

**PROPOSED AMENDMENT**

**7 CSR 10-1.020 Subpoenas.** The Missouri Highways and Transportation Commission is amending section (1).

*PURPOSE:* This amendment allows those specifically authorized to issue subpoenas the option to compel the attendance of witnesses by video conference in addition to in person.

(1) A request for a subpoena as authorized by section 622.360, RSMo, requiring a person to appear **in person or by video conference** and give sworn testimony, or to appear **in person or by video conference** and produce documents, records, or other physical evidence, shall be, by signed writing, directed to either the director, chief engineer, chief financial officer, assistant chief engineer, director of motor carrier services, or director of multimodal operations. The signed, written request shall include the name and address of the witness to be served, propose a suitable time and place for the witness's appearance, and reasonably describe the documents, records, or other physical evidence to be produced. In the case of corporate entities, the request may name the corporation and its registered agent for service of process, and defer to the corporation the designation of an informed corporate officer or safety designee to appear to so testify or produce the particular documents, records, or other physical evidence to be produced.

*AUTHORITY:* section 226.008, RSMo 2016. Original rule filed Jan. 27, 2004, effective Aug. 30, 2004. Amended: Filed Oct. 14, 2016, effective July 30, 2017. Amended: Filed June 3, 2022.

*PUBLIC COST:* This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars (\$500) in the aggregate.

*PRIVATE COST:* This proposed amendment will not cost private entities more than five hundred dollars (\$500) in the aggregate.

*NOTICE TO SUBMIT COMMENTS:* Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri Highways and Transportation Commission, Pamela J. Harlan, Secretary to the Commission, PO Box 270, Jefferson City, MO 65102 or Pamela.Harlan@modot.mo.gov. To be considered, comments must be received within thirty (30) days after publication of this notice in the *Missouri Register*. No public hearing is scheduled.

**Title 7—MISSOURI DEPARTMENT OF  
TRANSPORTATION  
Division 10—Missouri Highways and Transportation  
Commission  
Chapter 25—Motor Carrier Operations**

**PROPOSED AMENDMENT**

**7 CSR 10-25.010 Skill Performance Evaluation Certificates For Commercial Drivers.** The Missouri Highways and Transportation

Commission is amending sections (3) and (6), subsection (4)(C), and paragraphs (3)(C)2. and (3)(C)3.

*PURPOSE:* This amendment updates the publication date of the Application for Skill Performance Evaluation Certificate form which is incorporated by reference; removes text references to visual exemptions, visual examinations, and the medical professionals who perform visual examinations; and updates the publication dates of Title 49 of the *Code of Federal Regulations*, section 381.315, section 391.41, and section 391.49, which are incorporated by reference.

(3) Filing and Determination of Applications; Demonstration and Verification of Ability to Operate Commercial Motor Vehicles. Applications for an intrastate SPE certificate, and related documents, and information reasonably required by the director, shall be filed at PO Box 270, Jefferson City, MO 65102. Every application shall include all information and supporting documents required by section 622.555, RSMo, this rule, and the "Application for Skill Performance Evaluation Certificate." The application and accompanying instructions are incorporated herein by reference and made a part of this rule as published on [November] April 1/9/5, 20/18/22, by the Missouri Department of Transportation Motor Carrier Services Division, PO Box 270, Jefferson City, MO 65102. This rule does not incorporate any subsequent amendments or additions [of] to the application and instructions.

(C) At any time while an application is pending, or after the person is issued a SPE certificate, the director may require the person to demonstrate or verify the person's present ability to operate a commercial motor vehicle safely with his/her physical deficiency or impairment. These requirements may include:

1. Successfully completing a road test, using a commercial motor vehicle and associated equipment of the type which the applicant drives or seeks to drive pursuant to the SPE certificate;

2. Obtaining additional or periodic physical examinations by a psychiatrist[;], orthopedic surgeon[;], audiologist, or otolaryngologist[; ophthalmologist; or optometrist]; and

3. Filing additional or periodic reports with the director concerning the person's medical[, or hearing [or vision] examinations, treatment, prognosis, employment, driving record, accidents, traffic violations, and other pertinent information.

(4) Physical Deficiencies. Persons who are physically unqualified to drive commercial motor vehicles pursuant to any provision of Title 49, *Code of Federal Regulations* (CFR), section 391.41(b), may apply for intrastate SPE certificates, and the director may issue intrastate SPE certificates to those applicants, only if—

(C) With the exception of Subpart C, section 381.315, the commission incorporates by reference[, and makes a part of this rule[, the provisions of [Title] 49[, CFR [Part] 381 as published by the United States Government [Printing] Publishing Office, 732 North Capitol Street NW, Washington DC 20401, on [October 1] February 22, 20/18/22. The commission also incorporates by reference[, and makes a part of this rule[, the provisions of [Title] 49 CFR [Subpart] 391.41 as published by the United States Government [Printing] Publishing Office, 732 North Capitol Street NW, Washington, DC 20401, on [October 1] March 22, 20/18/22. The commission also incorporates by reference[, and makes a part of this rule[, the provisions of [Title] 49 CFR [Subpart] 391.49 as published by the United States Government [Printing] Publishing Office, 732 North Capitol Street NW, Washington, DC 20401, on [October 1] February 22, 20/18/22. This rule does not incorporate any subsequent amendments or additions to 49 CFR [Part] 381 [Subpart], 391.41, and [Subpart] 391.49.

(6) Federal Exemption or SPE Certification. Upon the filing of an application containing such information as the director may require, the director may waive any procedural requirements pursuant to this rule and shall issue an intrastate SPE certificate to any driver who is authorized to operate commercial motor vehicles in interstate commerce by

a currently valid SPE certificate[, or hearing[, or vision] exemption issued by the FMCSA. Each SPE certificate issued pursuant to this section shall be conditioned upon the driver's continued possession of the federal SPE certificate in good standing[, and the driver's compliance with all applicable requirements, including all conditions specified in the driver's federal SPE certificate, and any other conditions imposed by the director.

**AUTHORITY:** sections 226.008 and 622.555, RSMo 2016. Emergency rule filed June 6, 2003, effective June 16, 2003, expired Feb. 26, 2004. Original rule filed June 6, 2003, effective Dec. 30, 2003. Amended: Filed Oct. 14, 2016, effective July 30, 2017. Amended: Filed March 6, 2020, effective Oct. 30, 2020. Amended: Filed June 3, 2022.

**PUBLIC COST:** This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars (\$500) in the aggregate.

**PRIVATE COST:** This proposed amendment will not cost private entities more than five hundred dollars (\$500) in the aggregate.

**NOTICE TO SUBMIT COMMENTS:** Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri Highways and Transportation Commission, Pamela J. Harlan, Secretary to the Commission, PO Box 270, Jefferson City, MO 65102 or Pamela.Harlan@modot.mo.gov. To be considered, comments must be received within thirty (30) days after publication of this notice in the *Missouri Register*. No public hearing is scheduled.

## **Title 7—MISSOURI DEPARTMENT OF TRANSPORTATION**

### **Division 10—Missouri Highways and Transportation Commission Chapter 25—Motor Carrier Operations**

#### **PROPOSED AMENDMENT**

**7 CSR 10-25.030 Apportion Registration Pursuant to the International Registration Plan.** The Missouri Highways and Transportation Commission is amending section (2).

**PURPOSE:** This amendment updates the publication date of the *International Registration Plan*, which is incorporated by reference.

(2) Whenever the commission has entered into a reciprocal agreement providing for exemption from registration or the payment of registration fees on an apportionment basis with other member jurisdictions, the operator of a fleet of vehicles based in any one (1) of the member jurisdictions must comply with the provisions of the applicable agreement. The *International Registration Plan* (IRP) is a registration reciprocity agreement among the states of the United States, Washington D./C./, and the Canadian provinces and includes Missouri as a member. The IRP, published [July] **January 1, 2016/22**, is incorporated herein by reference and made a part of this rule as published by the International Registration Plan, Inc., 4196 Merchant Plaza, #225, Lake Ridge, VA 22192. This rule does not incorporate any subsequent amendments or additions.

**AUTHORITY:** sections 142.617, 226.008, 226.130, and 301.275, RSMo 2016. This rule originally filed as 12 CSR 20-3.010. Original rule filed July 22, 1965, effective Aug. 1, 1965. For intervening history, please consult the *Code of State Regulations*. Amended: Filed June 3, 2022.

**PUBLIC COST:** This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars (\$500) in the aggregate.

**PRIVATE COST:** This proposed amendment will not cost private entities more than five hundred dollars (\$500) in the aggregate.

**NOTICE TO SUBMIT COMMENTS:** Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri Highways and Transportation Commission, Pamela J. Harlan, Secretary to the Commission, PO Box 270, Jefferson City, MO 65102 or Pamela.Harlan@modot.mo.gov. To be considered, comments must be received within thirty (30) days after publication of this notice in the *Missouri Register*. No public hearing is scheduled.

## **Title 7—MISSOURI DEPARTMENT OF TRANSPORTATION**

### **Division 10—Missouri Highways and Transportation Commission Chapter 25—Motor Carrier Operations**

#### **PROPOSED AMENDMENT**

**7 CSR 10-25.070 Definitions.** The Missouri Highways and Transportation Commission is amending subsection (1)(A).

**PURPOSE:** This amendment revises the publication date of the *International Fuel Tax Agreement*, which is incorporated by reference.

(1) When used in administrative rules 7 CSR 10-25.070 through 7 CSR 10-25.073, the following words and phrases have the meaning set forth here in this rule:

(A) "Agreement" means the International Fuel Tax Agreement (IFTA), which is incorporated herein by reference and made a part of this rule as published by the International Fuel Tax Association, Inc., [912 West Chandler Blvd., B-7, Chandler] **PO Box 7147, Mesa, AZ 85225/16-7147**, revised [July] **January 1, 2015/22**. This rule does not incorporate any subsequent amendments or additions [of] to this manual;

**AUTHORITY:** sections 142.617, 226.008, 226.130, and 301.275, RSMo 2016. This rule originally filed as 12 CSR 20-7.010. Original rule filed Nov. 1, 1991, effective March 9, 1992. Moved to 7 CSR 10-25.070 and amended: Filed Aug. 9, 2007, effective Feb. 29, 2008. Amended: Filed Oct. 14, 2016, effective July 30, 2017. Amended: Filed June 3, 2022.

**PUBLIC COST:** This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars (\$500) in the aggregate.

**PRIVATE COST:** This proposed amendment will not cost private entities more than five hundred dollars (\$500) in the aggregate.

**NOTICE TO SUBMIT COMMENTS:** Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri Highways and Transportation Commission, Pamela J. Harlan, Secretary to the Commission, PO Box 270, Jefferson City, MO 65102 or Pamela.Harlan@modot.mo.gov. To be considered, comments must be received within thirty (30) days after publication of this notice in the *Missouri Register*. No public hearing is scheduled.

## **Title 7—MISSOURI DEPARTMENT OF TRANSPORTATION**

### **Division 10—Missouri Highways and Transportation Commission Chapter 25—Motor Carrier Operations**

#### **PROPOSED AMENDMENT**

**7 CSR 10-25.071 Application for International Fuel Tax Agreement License.** The Missouri Highways and Transportation

Commission is amending section (2).

*PURPOSE: This amendment clarifies how applications are accepted.*

(2) *[All initial a]*Applications will be accepted via United States mail, *[facsimile]* **electronically**, or in person. *[All subsequent applications may be filed electronically.]*

*AUTHORITY: sections 142.617, 226.008, 226.130, and 301.275, [RSMo 2000 and 226.008,] RSMo [Supp. 2007] 2016. This rule previously filed as 12 CSR 20-7.020. Original rule filed Nov. 1, 1991, effective March 9, 1992. Moved to 7 CSR 10-25.071 and amended: Filed Aug. 9, 2007, effective Feb. 29, 2008. Amended: Filed June 3, 2022.*

*PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars (\$500) in the aggregate.*

*PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars (\$500) in the aggregate.*

*NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri Highways and Transportation Commission, Pamela J. Harlan, Secretary to the Commission, PO Box 270, Jefferson City, MO 65102 or Pamela.Harlan@modot.mo.gov. To be considered, comments must be received within thirty (30) days after publication of this notice in the Missouri Register. No public hearing is scheduled.*

**Title 7—MISSOURI DEPARTMENT OF  
TRANSPORTATION  
Division 10—Missouri Highways and Transportation  
Commission  
Chapter 25—Motor Carrier Operations**

**PROPOSED AMENDMENT**

**7 CSR 10-25.080 Investigation and Audits.** The Missouri Highways and Transportation Commission is amending section (1).

*PURPOSE: The amendment revises the publication dates of the International Registration Plan and the International Fuel Tax Agreement documents, both of which are incorporated by reference, and updates the address of IFTA, Inc., the publisher of the IFTA agreement.*

(1) The commission may require reports from registrants/licensees as may be useful to assist the commission in performance of its duties. These reports shall furnish information as may be required by the International Registration Plan (IRP), which is incorporated herein by reference and made a part of this rule as published by the International Registration Plan, Inc., 4196 Merchant Plaza, #225, Lake Ridge, VA 22192, effective *[July]* **January 1, 20[16/22]**; and/or the International Fuel Tax Agreement (IFTA), which is incorporated herein by reference and made a part of this rule as published by the International Fuel Tax Association, Inc., *[912 West Chandler Blvd., B-7, Chandler]* **PO Box 7147, Mesa, AZ 852[25/16-7147]**, revised *[July]* **January 1, 20[15/22]**; and/or the commission and shall cover certain periods and be made at the times the commission may direct. This rule does not incorporate any subsequent amendments or additions *[of]* to the Plan or Agreement. These reports shall be in the form prescribed by the commission and shall be signed under certification as to the accuracy of the information included in such report. The aforementioned signatory shall be a person authorized to make such report on behalf of the registrant/licensee, which shall include~~/,~~ but not be limited to~~/,~~ the

president, vice-president, secretary, or other responsible officer or employee of a corporation or association or by a partner or a responsible employee of a partnership.

*AUTHORITY: sections 226.008, 226.130, and 301.275, RSMo 2016. This rule originally filed as 12 CSR 20-5.010. Original rule filed July 22, 1965, effective Aug. 1, 1965. For intervening history, please consult the Code of State Regulations. Amended: Filed June 3, 2022.*

*PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars (\$500) in the aggregate.*

*PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars (\$500) in the aggregate.*

*NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri Highways and Transportation Commission, Pamela J. Harlan, Secretary to the Commission, PO Box 270, Jefferson City, MO 65102 or Pamela.Harlan@modot.mo.gov. To be considered, comments must be received within thirty (30) days after publication of this notice in the Missouri Register. No public hearing is scheduled.*

**Title 7—MISSOURI DEPARTMENT OF  
TRANSPORTATION  
Division 10—Missouri Highways and Transportation  
Commission  
Chapter 25—Motor Carrier Operations**

**PROPOSED AMENDMENT**

**7 CSR 10-25.090 Appeals.** The Missouri Highways and Transportation Commission is amending section (2).

*PURPOSE: This amendment allows those participating in an informal review of a decision of the commission regarding the assessment of any tax, penalties, or interest under the agreement or plan the option to attend by video conference in addition to in person, in writing, or by telephone.*

(2) The informal review may be conducted in person, in writing, **by video conference**, or by telephone with Missouri Department of Transportation, Motor Carrier Services Division, personnel delegated such authority by the commission.

*AUTHORITY: sections 142.617, 226.008, 226.130 and 301.275, RSMo [2000 and 226.008, RSMo Supp. 2007] 2016. This rule previously filed as 12 CSR 20-7.060. Original rule filed Nov. 1, 1991, effective March 9, 1992. Moved to 7 CSR 10-25.090 and amended: Filed Aug. 9, 2007, effective Feb. 29, 2008. Amended: Filed June 3, 2022.*

*PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars (\$500) in the aggregate.*

*PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars (\$500) in the aggregate.*

*NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri Highways and Transportation Commission, Pamela J. Harlan, Secretary to the Commission, PO Box 270, Jefferson City, MO 65102 or Pamela.Harlan@modot.mo.gov. To be considered, comments must be received within thirty (30) days after publication of this notice in the Missouri Register. No public hearing is scheduled.*

**Title 7—MISSOURI DEPARTMENT OF  
TRANSPORTATION  
Division 265—Motor Carrier and Railroad Safety  
Chapter 10—Motor Carrier Operations**

**PROPOSED AMENDMENT**

**7 CSR 265-10.017 Records of the Division.** The Missouri Highways and Transportation Commission is amending paragraph (1)(A)3.

*PURPOSE:* This amendment updates the publication date of information from the United States Code that is incorporated by reference.

(1) The director of the Missouri Department of Transportation Motor Carrier Services division, or the director's designee, shall maintain a record of all proceedings filed with the Administrative Hearing Commission. Open records shall be available for public inspection and copying.

(A) The following records of the division, or possessed by the division, shall be closed records, and shall not be open to public inspection or copying, or made public, except as otherwise provided by order or permission of a court, the Administrative Hearing Commission, or when formally filed with the division in a hearing or proceeding, or when otherwise required to be made public under the rules of the division or Chapters 386—391, RSMo. The closure of records to public access under this subsection shall not be deemed to preclude lawful discovery of these records by a party in an administrative or court proceeding:

1. All records which may be closed records under Chapter 610, RSMo;

2. Under section 386.480, RSMo, all information furnished to the division or its employees by any motor carrier, their agents or employees, or by any corporation or person subject to the jurisdiction of the division, pursuant to the requirement of any statute or court order, any rule, order, or subpoena of the division or the Administrative Hearing Commission, or any audit, investigation, or discovery by the division staff, except that insurance certificates, surety bonds, endorsements, and cancellation notices filed pursuant to section 390.126, RSMo, or 7 CSR 265-10.030 shall be open records;

3. Under Title 49, United States Code (U.S.C.), section 523(c), which is incorporated herein by reference and made a part of this rule as published in 20/16/21 by the U.S. Government [Printing] Publishing Office, 732 North Capitol Street, NW, Washington, DC 20401-0001, and which does not incorporate any subsequent amendments or additions, all records or information acquired by division staff during an inspection of the equipment or records of a motor carrier or a lessor of equipment to such a carrier, if that inspection was delegated and funded or reimbursed by the Secretary of Transportation of the United States under Title 49 U.S.C., section 504, which is incorporated herein by reference and made a part of this rule as published in 20/16/21 by the U.S. Government [Printing] Publishing Office, 732 North Capitol Street, NW, Washington, DC 20401-0001, and which does not incorporate any subsequent amendments or additions; and

4. Under section 387.310, RSMo, any fact or information received by the division or its staff during the course of any inspection or examination of common carriers

*AUTHORITY:* section 622.027, RSMo 2016. This rule originally filed as 4 CSR 265-2.030. Emergency rule filed June 14, 1985, effective July 1, 1985, expired Oct. 28, 1985. Original rule filed Aug. 1, 1985, effective Oct. 29, 1985. For intervening history, please consult the *Code of State Regulations*. Amended: Filed June 3, 2022.

*PUBLIC COST:* This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars (\$500) in the aggregate.

*PRIVATE COST:* This proposed amendment will not cost private entities more than five hundred dollars (\$500) in the aggregate.

*NOTICE TO SUBMIT COMMENTS:* Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri Highways and Transportation Commission, Pamela J. Harlan, Secretary to the Commission, PO Box 270, Jefferson City, MO 65102 or Pamela.Harlan@modot.mo.gov. To be considered, comments must be received within thirty (30) days after publication of this notice in the *Missouri Register*. No public hearing is scheduled.

**Title 7—MISSOURI DEPARTMENT OF  
TRANSPORTATION  
Division 265—Motor Carrier and Railroad Safety  
Chapter 10—Motor Carrier Operations**

**PROPOSED AMENDMENT**

**7 CSR 265-10.025 Marking of Vehicles.** The Missouri Highways and Transportation Commission is amending section (1).

*PURPOSE:* This amendment revises the publication date of section 390.21 of Title 49, *Code of Federal Regulations*, which is incorporated by reference into this rule.

(1) Vehicle Markings. Every motor vehicle operated by a motor carrier in intrastate commerce under any property carrier registration, certificate, or permit issued by the Missouri Highways and Transportation Commission shall be marked in conformity with the requirements of section 390.21 of Title 49, *Code of Federal Regulations* (CFR) Part 390. The commission incorporates by reference in, and makes a part of this rule, the provisions of Title 49, CFR Part 390.21 as published by the United States Government [Printing] Publishing Office, 732 North Capitol Street NW, Washington DC 20401, on [September 24] August 14, 2013/9. This rule does not incorporate any subsequent amendments or additions to 49 CFR Part 390.21. Motor carriers operating a non-Commercial Driver's License (CDL) passenger-carrying vehicle having a capacity of fifteen (15) passengers or less, excluding the driver, may display on the vehicle's rear bumper, rear window, or otherwise on the rear of the vehicle, the United States Department of Transportation (USDOT) number assigned to the motor carrier, which shall be marked so it is readily legible during daylight hours from a distance of fifty feet (50') while a Commercial Motor Vehicle (CMV) is stationary and shall contrast sharply in color with the background on which the figures are placed.

*AUTHORITY:* section 622.027, RSMo 2016. This rule originally filed as 4 CSR 265-10.025. Emergency rule filed Dec. 1, 1994, terminated Dec. 19, 1994. Emergency rule filed Dec. 20, 1994, effective Jan. 1, 1995, expired April 30, 1995. Emergency rule filed April 20, 1995, effective May 1, 1995, expired Aug. 28, 1995. Emergency rule filed Aug. 18, 1995, effective Aug. 29, 1995, expired Feb. 24, 1996. Original rule filed Aug. 3, 1995, effective Feb. 25, 1996. Amended: Filed Aug. 5, 1999, effective March 30, 2000. Moved to 7 CSR 265-10.025, effective July 11, 2002. Rescinded and readopted: Filed May 2, 2013, effective Dec. 30, 2013. Amended: Filed Oct. 14, 2016, effective July 30, 2017. Amended: Filed June 3, 2022.

*PUBLIC COST:* This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars (\$500) in the aggregate.

*PRIVATE COST:* This proposed amendment will not cost private entities more than five hundred dollars (\$500) in the aggregate.

*NOTICE TO SUBMIT COMMENTS:* Anyone may file a statement in



*support of or in opposition to this proposed amendment with the Missouri Highways and Transportation Commission, Pamela J. Harlan, Secretary to the Commission, PO Box 270, Jefferson City, MO 65102 or Pamela.Harlan@modot.mo.gov. To be considered, comments must be received within thirty (30) days after publication of this notice in the Missouri Register. No public hearing is scheduled.*

**Title 7—MISSOURI DEPARTMENT OF  
TRANSPORTATION  
Division 265—Motor Carrier and Railroad Safety  
Chapter 10—Motor Carrier Operations**

**PROPOSED AMENDMENT**

**7 CSR 265-10.035 Application for a Self-Insurer Status.** The Missouri Highways and Transportation Commission is deleting the form which follows the rule in the *Code of State Regulations* and adding a new form, and amending section (1).

*PURPOSE: This amendment removes an obsolete form and replaces it with a form that meets current needs.*

(1) Motor carriers operating in intrastate commerce filing an application for authority to become a self-insurer shall file *[the original and one (1) copy of the]* **an** application with the director of the division. Every application shall include a completed Application *[F]for Self-Insurer Status Form, **included herein**, and[,]* whenever applicable~~[/]~~ shall include completed Exhibits A, B, C, D, and E, as described in the application form. The application may include additional supporting information, which shall not repeat or duplicate the information required in Application *[F]for Self-Insurer Status Form* or Exhibits A, B, C, D, and E. Photocopies of the form and exhibits are acceptable, if they are clearly legible.

 <b>Missouri Department of Transportation</b> Motor Carrier Services PO Box 270, 830 MoDOT Drive, Jefferson City, MO 65102-0270		E-mail: <a href="mailto:contracts@mo.gov">contracts@mo.gov</a> Phone: 866.831.6277 Fax: 573.522.6708	
<b>SELF-INSURER STATUS APPLICATION</b>			
<b>SECTION 1. REQUEST FOR SELF-INSURER STATUS (Check only one)</b>			
<input type="checkbox"/> 1. Applicant requests approval to be a self-insurer for the transportation of property or passengers in intrastate commerce <u>without</u> a self-insurance plan approved by the Federal Motor Carrier Safety Administration (See Section 4 for required attachments).			
<input type="checkbox"/> 2. Applicant requests approval to be a self-insurer for the transportation of property or passengers in intrastate commerce <u>pursuant</u> to a self-insurance plan approved by the Federal Motor Carrier Safety Administration (Attach copy of order in effect as Exhibit A).			
<b>SECTION 2. GENERAL INFORMATION</b>			
USDOT NO.	FMCSA NO.	FEIN/SSN (SSN Sole Proprietor Only)	
LEGAL NAME			
DOING BUSINESS AS (DBA) NAME			
PRINCIPAL PLACE OF BUSINESS ADDRESS (not a PO Box) - STREET		CITY	STATE <input type="text"/> ZIP CODE <input type="text"/>
MAILING ADDRESS (if different from Principal address) - STREET		CITY	STATE <input type="text"/> ZIP CODE <input type="text"/>
MISSOURI TERMINAL ADDRESS (if any) - STREET		CITY	STATE <input type="text"/> ZIP CODE <input type="text"/>
PHONE NO.	FAX NO.	E-MAIL ADDRESS	
<b>SECTION 3. FORM OF BUSINESS</b>			
<input type="checkbox"/> Sole Proprietor <input type="checkbox"/> Partnership <input type="checkbox"/> Limited Partnership <input type="checkbox"/> Limited Liability Partnership <input type="checkbox"/> Limited Liability Company <input type="checkbox"/> Corporation <input type="checkbox"/> Trust			
STATE OF ORGANIZATION/INCORPORATION		DATE ORGANIZED	CHARTER NO.
NAME OF COMPANY OFFICERS OR PARTNERS PLEASE PRINT		TITLE	
<b>SECTION 4. ATTACHMENTS FOR SELF-INSURER STATUS (Required only if #1 checked in Section 1).</b>			
The applicant has attached the following exhibits as required:			
Exhibit B -	Balance sheet prepared within the last six months prior to the filing of the application giving detailed information concerning the financial condition of the applicant.		
Exhibit C -	Income statement of applicant showing in detail its operating results for the twelve month period immediately prior to the date of the filing of the application.		
Exhibit D -	A record of all accidents, losses and claims filed in the five year period immediately prior to the date of the filing of the application and a complete explanation of the disposition of the claims.		
Exhibit E -	Information concerning the cancellation of any insurance policies issued to the applicant by insurance companies authorized to do business in this state, if such coverage related to applicant's operation as an authorized motor carrier.		
<b>SECTION 5. REQUIREMENTS OF A SELF-INSURER</b>			
If MoDOT grants authority to the applicant to be a self-insurer <u>with</u> a self insurance plan approved by the Federal Motor Carrier Safety Administration, applicant agrees to provide immediate notice of any proceeding or action by the Federal Motor Carrier Safety Administration, which could result in or has resulted in the suspension, revocation or termination of its self-insurance plan by the Federal Motor Carrier Safety Administration.			
If MoDOT grants authority to the applicant to be a self-insurer <u>without</u> a self insurance plan approved by the Federal Motor Carrier Safety Administration, the applicant may be required to place in a separate account a minimum reserve amount based upon the carrier's size, operations and claims history.			
If MoDOT grants authority to the applicant to be a self-insurer <u>without</u> a self insurance plan approved by the Federal Motor Carrier Safety Administration, the applicant agrees to file annually, within sixty days after the close of the calendar year, a balance sheet and income statement and a statement listing any claims filed against the applicant with arose out of any accidents the applicant was involved in during its operations in the previous calendar year, and any unresolved claims which arose out of such accidents during previous years. For each claim listed, the applicant will state the amount, nature and status of the claim, including whether it is disputed or undisputed, and how much of it remains unpaid.			
<b>SECTION 6. SIGNATURE (An attorney is not required to sign on behalf of a corporation)</b>			
Applicant, by signing below, agrees to comply with all federal and state safety laws and regulations before the permit, certificate or carrier registration has been issued and before the applicant commences for-hire motor carrier movements. This applicant by signature on and/or delivery of this application to Motor Carrier Services consents on behalf of itself, its affiliates and other persons or entities under its control to be investigated by MoDOT in relationship to the applicant's safety fitness or insurance coverage. This consent extends to a search for and recovery of all evidence relating to compliance with state, federal and local laws. Under penalty of perjury under the laws of the state of Missouri and the United States of America, applicant certifies that the information on this application or attached hereto is true and correct, is authorized to sign this application on behalf of applicant and that the signature is applicant's own true and correct signature made by self or legal representative and by no other person.			
Applicant Name Printed	Applicant Signature	Title	Date
If attorney signed on behalf of applicant, print address			MO Bar No.

**AUTHORITY:** section 622.027, RSMo [2000] 2016. This rule originally filed as 4 CSR 265-2.068. Emergency rule filed Aug. 1, 1986, effective Aug. 13, 1986, expired Oct. 23, 1986. Original rule filed July 31, 1986, effective Oct. 27, 1986. For intervening history, please consult the *Code of State Regulations*. Amended: Filed June 3, 2022.

**PUBLIC COST:** This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars (\$500) in the aggregate.

**PRIVATE COST:** This proposed amendment will not cost private entities more than five hundred dollars (\$500) in the aggregate.

**NOTICE TO SUBMIT COMMENTS:** Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri Highways and Transportation Commission, Pamela J. Harlan, Secretary to the Commission, PO Box 270, Jefferson City, MO 65102 or Pamela.Harlan@modot.mo.gov. To be considered, comments must be received within thirty (30) days after publication of this notice in the *Missouri Register*. No public hearing is scheduled.

**Title 13—DEPARTMENT OF SOCIAL SERVICES  
Division 70—MO HealthNet Division  
Chapter 15—Hospital Program**

**PROPOSED AMENDMENT**

**13 CSR 70-15.010 Inpatient Hospital Services Reimbursement Methodology.** The division is amending sections (1)–(11) and adding sections (12)–(15).

**PURPOSE:** This proposed amendment changes the inpatient reimbursement methodology and deletes or clarifies outdated terms, language, and provisions regarding inpatient hospital services reimbursement methodologies.

**(1) General Reimbursement Principles.**

(A) For inpatient hospital services provided for an individual entitled to Medicare Part A inpatient hospital benefits and eligible for MO HealthNet, reimbursement from the MO HealthNet Program will be available only when MO HealthNet's applicable payment schedule amount exceeds the amount paid by Medicare. MO HealthNet's payment will be limited to the lower of the deductible and coinsurance amounts or the amount the MO HealthNet applicable payment schedule amount exceeds the Medicare payments. For all other MO HealthNet participants, unless otherwise limited by rule, reimbursement will be based solely on the individual participant's days of care (within benefit limitations) multiplied by the individual hospital's Title XIX *[per diem] per diem* rate. *[As described in paragraph (5)(D)2. of this rule, as part of each hospital's fiscal year-end cost settlement determination, a comparison of total MO HealthNet-covered aggregate charges and total MO HealthNet payments will be made and any hospital whose aggregate MO HealthNet per diem payments exceed aggregate MO HealthNet charges will be subject to a retroactive adjustment.]*

*[(B) The Title XIX reimbursement for hospitals located outside Missouri and for federally-operated hospitals in Missouri will be determined as stated in 13 CSR 70-15.190.]*

*[(C)](B) The Title XIX reimbursement for hospitals, excluding those located outside Missouri [and in-state federal hospitals], shall include [per diem payments, outpatient payments, disproportionate share payments, and various MO HealthNet Add-On payments] the payments as outlined below. Reimbursement shall be subject to availability of federal financial participation (FFP).*

1. **Inpatient *[Per diem] per diem* reimbursement** is established in accordance with *[section (3)] sections (4) and (5)*.

2. **Outpatient reimbursement** is *[described]* established in accordance with 13 CSR 70-15.160.

3. *[Disproportionate share payments are described in 13 CSR 70-15.220.]* **Acuity adjustment payment (AAP)** is established in accordance with section (6).

4. *[MO HealthNet Add-Ons are described in sections (9) and (10) of this rule and 13 CSR 70-15.015 and are in addition to MO HealthNet per diem payments. These payments are subject to the federal Medicare Upper Limit test]* **Poison control (PC) payment** is established in accordance with section (7).

5. **Stop loss payment (SLP)** is established in accordance with section (8).

6. **Disproportionate share hospital (DSH) payment** is established in accordance with 13 CSR 70-15.220.

7. **Graduate medical education (GME) payment** is established in accordance with section (9).

8. **Upper payment limit (UPL) payment** is established in accordance with 13 CSR 70-15.230.

9. **Children's outlier (CO) payment** is established in accordance with section (10).

(C) The Title XIX reimbursement for hospitals located outside Missouri will be established in accordance with 13 CSR 70-15.190.

**(2) Definitions.**

(A) **Allowable costs.** Allowable costs are those related to covered MO HealthNet services defined as allowable in 42 CFR chapter IV, part 413, except as specifically excluded or restricted in 13 CSR 70-15.010 or the MO HealthNet hospital provider manual and detailed on the *[desk-reviewed Medicare/audited]* Medicaid cost report. Penalties or incentive payments as a result of Medicare target rate calculations shall not be considered allowable costs. Implicit in any definition of allowable cost is that this cost is allowable only to the extent that it relates to patient care; is reasonable, ordinary, and necessary; and is not in excess of what a prudent and cost-conscious buyer pays for the given service or item. *[For purposes of calculating disproportionate share payments and to ensure federal financial participation (FFP), allowable uncompensated costs must meet definitions defined by the federal government.]*

(C) **Base year cost report.** *[Desk-reviewed Medicare/audited]* Medicaid cost report **from the third prior calendar year.** *[When]* If a facility has more than one (1) cost report with periods ending in the *[fourth] third* prior calendar year, the cost report covering a full twelve- (12-) month period will be used. If none of the cost reports covers a full twelve (12) months, the cost report with the latest period will be used. If a hospital's base year cost report is less than or greater than a twelve- (12-) month period, the data shall be adjusted, based on the number of *[months]* days reflected in the base year cost report to a twelve- (12-) month period. **Any changes to the base year cost report after the division issues a final decision on assessment or payments will not be included in the calculations.**

(D) **Case mix index (CMI).** The hospital CMI for the AAP is determined based on the hospital's MO HealthNet inpatient claims and 3M™ All-Patient Refined Diagnosis Related Groups (APR-DRG) software, a grouping algorithm to categorize inpatient discharges with similar treatment characteristics requiring similar hospital resources.

1. **For State Fiscal Year (SFY) 2023, each hospital's CMI was calculated as follows:**

A. A dataset of complete inpatient stays was established using MO HealthNet fee-for-service claims and managed care encounters combined for calendar years 2019 and 2020. A two-(2-) year dataset was used to account for the potential impact of changes to hospital utilization, costs, and mix of patients due to the COVID-19 public health emergency;

**B. Interim claims where multiple claims cover a single inpatient stay were combined into single claims covering the complete inpatient stay;**

**C. The 3M™ APR-DRG grouping software was applied to the inpatient dataset, using version 38 of the grouper. Each inpatient stay was assigned to a single DRG and severity of illness level. Each APR-DRG is associated with a relative weight reflecting the relative amount of resources required to care for similar stays, compared to an average inpatient stay. APR-DRG weights are provided by 3M™ and are calculated based on a national all-payer population;**

**D. The national weights were recentered to reflect the average resource requirements within the MO HealthNet population, including both fee-for-service and managed care encounter inpatient stays. Recentered weights are calculated by dividing the APR-DRG national weights by the average case mix for all hospitals. The average case mix is calculated as the sum of the national weights for each inpatient stay divided by the number of stays for all hospitals;**

**E. A hospital-specific CMI is calculated by summing the MO HealthNet recentered weights for each inpatient stay and dividing the total by the number of inpatient stays for the hospital.**

**2. For SFY 2024 and forward, the basis of the case mix index will be determined by the division based on combined inpatient stays from the second and third prior calendar years, the current version of the 3M™ APR-DRG grouper, relative weights appropriate for the MO HealthNet population, and the SFY in which an AAP is being calculated.**

**[(D)](E) Charity care.** Results from a provider's policy to provide health care services free of charge or a reduction in charges because of the indigence or medical indigence of the patient.

**[(E)](F) Contractual allowances.** Difference between established rates for covered services and the amount paid by third-party payers under contractual agreements.

**[(F)](G) Cost report.** A cost report details, for purposes of both Medicare and MO HealthNet reimbursement, the cost of rendering covered services for the fiscal reporting period. The Medicare/Medicaid Uniform Cost Report contains the forms utilized in filing the cost report. The Medicare/Medicaid Cost Report version 2552-10 (CMS 2552-10) shall be used for fiscal years beginning on and after May 1, 2010.

**[(G)] Critical access.** Hospitals which meet the federal definition found in section 1820(c)(2)(B) of the Social Security Act. A Missouri expanded definition of critical access shall also include hospitals which meet the federal definitions of both a rural referral center and sole community provider and is adjacent to at least one (1) county that has a Medicaid eligible population of at least twenty-five percent (25%) of the total population of the county or hospitals which are the sole community hospital located in a county that has a Medicaid population of at least twenty-five percent (25%) of the total population of the county.

**(H) Disproportionate share reimbursement.** The disproportionate share payments are described in 13 CSR 70-15.220.

**(I) Effective date.**

1. The plan effective date shall be October 1, 1981.

2. The adjustment effective date shall be thirty (30) days after notification to the hospital that its reimbursement rate has been changed unless modified by other sections of the plan.]

**(H) Division.** Unless otherwise designated, division refers to the MO HealthNet Division (MHD) a division of the Department of Social Services charged with the administration of the MO HealthNet program.

**[(J)](I) [MO HealthNet] Medicaid inpatient days.** [MO HealthNet] Medicaid inpatient days are paid [MO HealthNet] Medicaid days for inpatient hospital services as reported by the

Medicaid Management Information System (MMIS).

**[(K)] Medicare rate.** The Medicare rate is the rate established on the basis of allowable cost as defined by applicable Medicare standards and principles of reimbursement (42 CFR parts 405 and 413) as determined by the servicing fiscal intermediary based on yearly hospital cost reports. ]

**[(L)](J) Nonreimbursable items.** For purposes of reimbursement of reasonable cost, the following are not subject to reimbursement:

1. Allowances for return on equity capital;

2. Amounts representing growth allowances in excess of the intensity allowance, profits, efficiency bonuses, or a combination of these;

3. Cost in excess of the principal of reimbursement specified in 42 CFR chapter IV, part 413; and

4. Costs or services specifically excluded or restricted in this [plan] rule or the MO HealthNet hospital provider manual.

**[(M)] Per diem rates.** The per diem rates shall be determined from the individual hospital cost report in accordance with section (3) of this regulation.]

**[(N)](K) Reasonable cost.** The reasonable cost of inpatient hospital services is an individual hospital's [MO HealthNet per diem] Medicaid cost per day as determined in accordance with [the general plan rate calculation from section (3)] section (4) of this regulation using the base year cost report.

**[(O)](L) Specialty pediatric hospital.** An inpatient pediatric acute care facility which—

1. Is licensed as a hospital by the Missouri Department of Health and Senior Services under Chapter 197 of the Missouri Revised Statutes;

2. Has been granted substantive waivers by the Missouri Department of Health and Senior Services from compliance with material hospital licensure requirements governing a) the establishment and operation of an emergency department, and b) the provision of pathology, radiology, laboratory, and central services; and

3. Is not licensed to operate more than sixty (60) inpatient beds.

**[(P)](M) Trend factor.** The trend factor is a measure of the change in costs of goods and services purchased by a hospital during the course of one (1) year.

**[(Q)] Children's hospital.** An acute care hospital operated primarily for the care and treatment of children under the age of eighteen (18) years old and which has designated in its licensure application at least sixty-five percent (65%) of its total licensed beds as a pediatric unit.]

**[(R)](N) [FRA] Federal reimbursement allowance (FRA).** The fee assessed to hospitals for the privilege of engaging in the business of providing inpatient health care in Missouri. The FRA shall be an allowable cost to the hospital. The [Federal Reimbursement Allowance (FRA)] is identified in 13 CSR 70-15.110. Effective January 1, 1999, the assessment shall be an allowable cost.

**[(S)](O) [Incorporates] Incorporation** by [R]reference. This rule incorporates by reference the following:

1. The Hospital Provider Manual is incorporated by reference and made a part of this rule as published by the Department of Social Services, MO HealthNet Division, 615 Howerton Court, Jefferson City, MO 65109, at its website at <http://manuals.momed.com/manuals/>, [March 6, 2020] June 8, 2022. This rule does not incorporate any subsequent amendments or additions; [and]

2. Medicare/Medicaid Cost Report CMS 2552-10, which is incorporated by reference and made a part of this rule as published by the Centers for Medicare [and] & Medicaid Services (CMS) at its website <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Paper-Based-Manuals-Items/CMS021935.html>, [February 18, 2020] June 8, 2022. This rule does not incorporate any subsequent amendments or additions.;]

3. 42 CFR 405, which is incorporated by reference and made a part of this rule as published by the U.S. Government

Publishing Office and available at <https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-405?toc=1>, June 8, 2022. This rule does not incorporate any subsequent amendments or additions; and

4. 42 CFR 413, which is incorporated by reference and made a part of this rule as published by the U.S. Government Publishing Office and available at <https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-413?toc=1>, June 8, 2022. This rule does not incorporate any subsequent amendments or additions.

[(3) *Per Diem Reimbursement Rate Computation.* Each hospital shall receive a MO HealthNet per diem rate based on the following computation:

(A) The per diem rate shall be determined from the 1995 base year cost report in accordance with the following formula:

$$\text{Per Diem} = \frac{(\text{OC} * \text{TI})}{\text{MPD}} + \frac{\text{CMC}}{\text{MPDC}}$$

1. OC—The operating component is the hospital's total allowable cost (TAC) less CMC;

2. CMC—The capital and medical education component of the hospital's TAC;

3. MPD—Medicaid inpatient days;

4. MPDC-MPD—Medicaid patient days for capital costs as defined in paragraph (3)(A)3. with a minimum utilization of sixty percent (60%) as described in paragraph (5)(C)8.;

5. TI—Trend indices. The trend indices are applied to the OC of the per diem rate. The trend index for SFY 1995 is used to adjust the OC to a common fiscal year end of June 30. The adjusted OC shall be trended through SFY 2001;

6. TAC—Allowable inpatient routine and special care unit expenses, ancillary expenses, and graduate medical education costs will be added to determine the hospital's total allowable cost (TAC);

7. The per diem shall not exceed the average MO HealthNet inpatient charge per diem as determined from the base year cost report and adjusted by the TI;

8. The per diem shall be adjusted for rate increases granted in accordance with subsection (5)(F) for allowable costs not included in the base year cost report; and

(B) Trend Indices (TI). Trend indices starting in SFY 2016 will be determined based on the Hospital Market Basket index as published in Healthcare Cost Review by Institute of Health Systems (IHS), or equivalent publication, regardless of any changes in the name of the publication or publisher, for each State Fiscal Year (SFY).

1. The per diem rate shall be reduced as necessary to avoid any negative Direct Medicaid payments computed in accordance with 13 CSR 70-15.015.

2. A facility previously enrolled for participation in the MO HealthNet Program, which either voluntarily or involuntarily terminates its participation in the MO HealthNet Program and which reenters the MO HealthNet Program, will receive the same inpatient rate and outpatient rate as the previous owner/operator. Such facility will also receive the same Direct Medicaid Add-On Payment and Uninsured Add-On Payment as the previous owner/operator if the facility reenters the MO HealthNet Program during the same state fiscal year. If the facility does not reenter during the same state fiscal year, the Direct Medicaid Add-On Payment and Uninsured Add-On Payment will be determined based on the applicable base year data (i.e., fourth prior year cost report for the Direct Medicaid Payment; see 13 CSR 70-15.220 for the applicable data for the Uninsured Add-On Payment). If the facility does not have the applicable base year data, the

Direct Medicaid Add-On Payment and the Uninsured Add-On Payment will be based on the most recent audited data available and will include annual trend factor adjustments from the year subsequent to the cost report period through the state fiscal year for which the payments are being determined.

(4) *Per Diem Rate—New Hospitals.*

(A) In the absence of adequate cost data, a new facility's initial MO HealthNet rate shall be ninety percent (90%) of the average-weighted, statewide per diem rate for the year it became certified to participate in the MO HealthNet program until a prospective rate is determined on the facility's rate setting cost report as set forth below in paragraph (4)(A)1. The facility's rate setting cost report shall be the first full fiscal year cost report. If the facility's first full fiscal year cost report does not include any Medicaid costs, the facility shall continue to receive the initial rate, and the prospective rate will be determined from the facility's second full fiscal year cost report. If the facility's second full fiscal year cost report does not include any Medicaid cost, the initial rate shall become the facility's prospective rate and shall be effective the date the facility was enrolled in the MO HealthNet program. The effective date for facilities whose prospective rate was based on the rate setting cost report shall be the first day of the SFY that the rate setting cost report is the base year cost report for determining the Direct Medicaid Add-On Payment as described in 13 CSR 70-15.015.

1. Prospective Per Diem Reimbursement Rate Computation. Each new hospital shall receive a MO HealthNet prospective per diem rate based on the sum of the following components:

A. Total Allowable Cost, less Graduate Medical Education cost, adjusted by the Trend Indices in subsection (3)(B) from the year subsequent to the rate setting cost report period through the state fiscal year for which the rate is being determined, divided by Medicaid Inpatient Days; plus

B. Graduate Medical Education cost divided by Medicaid Inpatient Days.

2. The per diem rate shall not exceed the average MO HealthNet inpatient charge per day as determined from the rate setting cost report as adjusted by the applicable Trend Indices.

3. The per diem rate shall be adjusted for rate increases granted in accordance with subsection (5)(F) for allowable costs not included in the rate setting cost report.

4. The per diem rate shall be reduced as necessary to avoid any negative Direct Medicaid Payments computed in accordance with 13 CSR 70-15.015.

(B) In addition to the MO HealthNet rate determined by subsection (4)(A), the MO HealthNet per diem rate for a new hospital licensed after February 1, 2007, shall include an adjustment for the hospital's estimated Direct Medicaid Add-On Payment per patient day, as determined in 13 CSR 70-15.015, until the facility's prospective rate is set in accordance with subsection (4)(A). The facility's Direct Medicaid Add-On adjustment will then no longer be included in the per diem rate but shall be calculated as a separate Add-On Payment, as set forth in 13 CSR 70-15.015.]

[(5)](3) Reporting Requirements.

(A) Cost [R]eports.

1. Each hospital participating in the MO HealthNet program shall submit a cost report in the manner prescribed by the [state MO HealthNet agency] division. The cost report shall be submitted within five (5) calendar months after the close of the reporting period. The period of a cost report is defined in 42 CFR 413.24(f). [A

*single extension, not to exceed thirty (30) days, may be granted upon the request of the hospital and the approval of the MO HealthNet Division when the provider's operation is significantly affected due to extraordinary circumstances over which the provider had no control such as fire or flood. The request must be in writing and postmarked prior to the first day of the sixth month following the hospital's fiscal year end.]*

A. All cost reports shall be submitted and certified by an officer or administrator of the hospital.

B. If a cost report is more than ten (10) days past due, the division may withhold fifty thousand dollars (\$50,000) in MO HealthNet payments from the hospital until the hospital submits the cost report. If the MO HealthNet payment is less than fifty thousand dollars (\$50,000), the entire payment will be withheld. Upon the division's or its authorized contractor's receipt of the cost report prepared in accordance with this regulation, the payment that was withheld will be released to the hospital.

C. A single extension, not to exceed thirty (30) days, may be granted upon the request of the hospital and the approval of the division when the hospital's operation is significantly affected due to extraordinary circumstances over which the hospital had no control, such as fire or flood. The request must be in writing and postmarked prior to the first day of the sixth month following the hospital's fiscal year end.

2. The change of control[, or ownership[, or termination] of [or by] a hospital of participation in the program requires that the hospital submit a cost report for the period ending with the date of change of control[, or ownership[, or termination] within five (5) calendar months after the close of the reporting period. [No extensions in the submitting of cost reports shall be allowed when a termination of participation has occurred.]

[A. If a provider notifies, in writing, the director of the Institutional Reimbursement Unit of the division prior to the change of control, ownership, or termination of participation in the MO HealthNet program, the division will withhold all remaining payments from the selling provider until the cost report is filed. Upon receipt of a cost report prepared in accordance with this regulation, any payment that was withheld will be released to the selling provider.

B. If the director of the Institutional Reimbursement Unit does not receive, in writing, notification of a change of control or ownership upon learning of a change of control or ownership, fifty thousand dollars (\$50,000) of the next available MO HealthNet payment, after learning of the change of control or ownership, will be withheld from the provider identified in the current MO HealthNet participation agreement until a cost report is filed. If the MO HealthNet payment is less than fifty thousand dollars (\$50,000), the entire payment will be withheld. Once the cost report prepared in accordance with this regulation is received, the payment will be released to the provider identified in the current MO HealthNet participation agreement.]

A. Upon learning of a change of control or ownership, the division may withhold fifty thousand dollars (\$50,000) of the next available MO HealthNet payment from the hospital identified in the current MO HealthNet participation agreement until the cost report is filed. If the MO HealthNet payment is less than fifty thousand dollars (\$50,000), the entire payment will be withheld. Once the cost report prepared in accordance with this regulation is received, the payment will be released to the hospital identified in the current MO HealthNet participation agreement.

[C./B. The [MO HealthNet D]division may, at its discretion, delay the withholding of funds specified in subparagraph[s] [(5)(A)2.A. and B.](3)(A)2.A. until the cost report is due based on assurances satisfactory to the division that the cost report will be timely filed. A request jointly submitted by the buying and selling [provider] entities may provide adequate assurances. The buying

[provider] entity must accept responsibility for ensuring timely filing of the cost report and authorize the division to immediately withhold fifty thousand dollars (\$50,000) if the cost report is not timely filed.

3. [All cost reports shall be submitted and certified by an officer or administrator of the provider. Failure to file a cost report, within the period prescribed in this subsection, may result in the impositions of sanctions as described in 13 CSR 70-3.030.] The termination of or by a hospital of participation in the MO HealthNet program requires that the hospital submit a cost report for the period ending with the date of termination within five (5) calendar months from the date of the CMS tie-out notice. No extension in the submitting of cost reports shall be allowed when a termination of participation has occurred.

A. Upon learning of the termination, the division may withhold fifty thousand dollars (\$50,000) of the next available MO HealthNet payment from the hospital until the cost report is filed. If the MO HealthNet payment is less than fifty thousand dollars (\$50,000), the entire payment will be withheld. Upon the division's or its authorized contractor's receipt of the cost report prepared in accordance with this regulation, the payment that was withheld will be released to the hospital.

4. Amended cost reports or other supplemental. The division or its authorized contractor will notify the hospital by letter when the [desk review] audit of its cost report is completed. Since this data [may] will be used in the calculation of [per diem] per diem rates, [direct payments, trended costs, or uninsured add-on] and other Medicaid payments, the hospital shall review the [desk review] audited cost report data [and the schedule of key data elements] and submit amended or corrected data to the division or its authorized contractor within fifteen (15) days. Data received after the fifteen- (15-) day deadline will not be considered by the division for [per diem] per diem rates, [direct payments, trended costs, or uninsured] or other Medicaid payments unless the hospital requests in writing and receives an extension to file additional information prior to the end of the fifteen- (15-) day deadline.

(B) Records.

1. All hospitals are required to maintain financial and statistical records in accordance with 42 CFR 413.20. For purposes of this plan, statistical and financial records shall include beneficiaries' medical records and patient claim logs separated for inpatient and outpatient services billed to and paid for by MO HealthNet (excluding cross-over claims) respectively. [Separate logs for inpatient and outpatient services should be maintained for MO HealthNet participants covered by managed care.] All records must be available upon request to representatives, employees, or contractors of the MO HealthNet program, Missouri Department of Social Services, General Accounting Office (GAO), or the United States Department of Health and Human Services (HHS). The content and organization of the inpatient and outpatient logs shall include the following:

A. A separate [MO HealthNet] log for each fiscal year must be maintained by either date of service or date of payment [by MO HealthNet] for claims and all adjustments of those claims for services provided in the fiscal period. Lengths of stay covering two (2) fiscal periods should be recorded by date of admission. The information from the [MO HealthNet] log should be used to complete the Medicaid worksheet in the hospital's cost report;

[B. Data required to be recorded in logs for each claim include:

(I) Participant name and MO HealthNet number;

(II) Dates of service;

(III) If inpatient claim, number of days paid for by MO HealthNet, classified by adults and peds, each sub-provider, newborn, or specific type of intensive care;

(IV) Charges for paid inpatient days and inpatient ancillary charges for paid days classified by cost center as

reported in the cost report or allowed outpatient services, classified by cost center as reported on cost report;

(V) Noncovered charges combined under a separate heading;

(VI) Total charges;

(VII) Any partial payment made by third-party payers (claims paid equal to or in excess of MO HealthNet payment rates by third-party payers shall not be included in the log);

(VIII) MO HealthNet payment received or the adjustment taken; and

(IX) Date of remittance advice upon which paid claim or adjustment appeared;]

[C.]B. A year-to-date total must appear at the bottom of each log page or after each applicable group total, or a summation page of all subtotals for the fiscal year activity must be included with the log; and

[D.]C. Not to be included in the [outpatient] logs are **denied** claims or line item [outpatient] charges [denied by MO HealthNet or claims or charges paid from an established MO HealthNet fee schedule]. This would include payments for hospital-based physicians and certified registered nurse anesthetists billed by the hospital on a professional services claim[, payments for certain specified clinical diagnostic laboratory services,] or payments for services provided by the hospital through enrollment as a MO HealthNet provider-type other than hospital [outpatient].

2. Records of related organizations, as defined by 42 CFR 413.17, must be available upon demand to those individuals or organizations as listed in paragraph [(5)(B)1.] (3)(B)1. of this rule.

[3. The MO HealthNet Division shall retain all uniform cost reports submitted for a period of at least three (3) years following the date of submission of the reports and will maintain those reports pursuant to the record-keeping requirements of 42 CFR 413.20. If an audit by, or on behalf of, the state or federal government has begun but is not completed at the end of the three- (3-) year period, or if audit findings have not been resolved at the end of the three- (3-) year period, the reports shall be retained until resolution of the audit findings.

4. The MO HealthNet Division shall maintain any responses received on this plan, subsequent changes to this plan, and rates for a period of three (3) years from the date of receipt.

(C) New, Expanded, or Terminated Services. A hospital, at times, may offer to the public new or expanded inpatient services which may require Certificate of Need (CON) approval, or may permanently terminate a service.

1. A state hospital, i.e., one owned or operated by the board of curators as provided for in Chapter 172, RSMo, or one owned or operated by the Department of Mental Health, may offer new or expanded inpatient services to the public provided it receives legislative appropriations for the project. A state hospital may submit a request for inpatient rate reconsideration if the project meets or exceeds a cost threshold of one (1) million dollars for capital expenditures or one (1) million dollars for major medical equipment expenditures as described in 19 CSR 60-50.300.

2. Nonstate hospitals may also offer new or expanded inpatient services to the public, and incur costs associated with the additions or expansions which may qualify for inpatient rate reconsideration requests. Such projects may require a Certificate of Need (CON). Rate reconsideration requests for projects requiring CON review must include a copy of the CON program approval. Nonstate hospitals may request inpatient rate reconsiderations for projects not requiring review by the CON program, provided each project meets or exceeds a cost threshold of one (1) million dollars for capital expenditures as described in 19 CSR 60-50.300.

3. A hospital (state or nonstate) will have six (6) months after the new or expanded service project is completed and the service is offered to the public to submit a request for inpatient rate reconsideration, along with a budget of the project's costs. The rate reconsideration request and budget will be subject to desk review and audit. Upon completion of the desk review and audit, the hospital's inpatient reimbursement rates may be adjusted, if indicated. Failure to submit a request for rate reconsideration and project budget within the six- (6-) month period shall disqualify the hospital from receiving a rate increase prior to recognizing the increase through the trended cost calculation (direct Medicaid payments). Failure to submit a request shall not prohibit the division from reducing the rate in the case of a terminated service.

4. Failure to submit a budget concerning terminated services may result in the imposition of sanctions as described in 13 CSR 70-3.030.

5. The effective date for any increase granted under this subsection shall be no earlier than the first day of the month following the MO HealthNet Division's final determination on rate reconsideration.

6. Any inpatient rate reconsideration request for new, expanded, or terminated services must be submitted in writing to the MO HealthNet Division and must specifically and clearly identify the issue and total dollar amount involved. The total dollar amount must be supported by generally accepted accounting principles. The hospital shall demonstrate the adjustment is necessary, proper, and consistent with efficient and economical delivery of covered patient care services. The hospital will be notified in writing of the agency's decision within sixty (60) days of receipt of the hospital's written request or within sixty (60) days of receipt of any additional documentation or clarification which may be required, whichever is later. Failure to submit requested information within the sixty- (60-) day period shall be grounds for denial of the request. If the state does not respond within the sixty- (60-) day period, the request shall be deemed denied.

7. Rate adjustments due to new or expanded services will be determined as total allowable project cost (i.e., the sum of annual depreciation, annualized interest expense, and annual additional operating costs) multiplied by the ratio of total inpatient costs (less skilled nursing facility (SNF) and swing bed cost) to total hospital cost as submitted on the most recent cost report filed with the agency as of the review date divided by total acute care patient days including all special care units and nursery, but excluding swing bed days.

8. Total acute care patient days (excluding nursery and swing bed days) must be at least sixty percent (60%) of total possible bed days. Total possible bed days will be determined using the number of licensed beds times three hundred sixty-five (365) days. If the days, including neonatal units, are less than sixty percent (60%), the sixty percent (60%) number plus newborn days will be used to determine the rate increase. This computation will apply to capital costs only.

9. Major medical equipment costs included in rate reconsideration requests shall not include costs to replace current major medical equipment if the replacement does not result in new or expanded inpatient services. The replacement of inoperative or obsolete major medical equipment, by itself, does not qualify for rate reconsideration, even if the new equipment costs at least one (1) million dollars.

(D) Audits.

1. A comprehensive hospital audit program shall be established in cooperation with the Missouri Medicare fiscal



intermediary. Under the terms of the Common Audit Agreement, the Medicare intermediary shall perform the following:

- A. Desk review all hospital cost reports;
- B. Determine the scope and format for on-site audits;
- C. Perform field audits when indicated in accordance with Title XIX principles; and
- D. Submit to the state agency the final Title XVIII cost report with respect to each provider.

(E) *Adjustments to Rates.* The prospectively determined individual hospital's reimbursement rate may be adjusted only under the following circumstances:

- 1. When information contained in the cost report is found to be intentionally misrepresented. The adjustment shall be made retroactive to the date of the original rate. This adjustment shall not preclude the MO HealthNet Division from imposing any sanctions authorized by any statute or rule; or
- 2. When rate reconsideration is granted in accordance with subsection (5)(F).

(F) *Rate Reconsideration.*

1. Rate reconsideration may be requested under this subsection for changes in allowable cost which occur subsequent to the base period described in subsection (3)(A). The effective date for any increase granted under this subsection shall be no earlier than the first day of the month following the MO HealthNet Division's final determination on rate reconsideration.

2. The following may be subject to review under procedures established by the MO HealthNet Division:

- A. New, expanded, or terminated services as detailed in subsection (5)(C);
- B. When the hospital experiences extraordinary circumstances which may include, but are not limited to, an act of God, war, or civil disturbance; and
- C. Per diem rate adjustments for critical access hospitals.

(I) *Critical access hospitals meeting either the federal definition or the Missouri expanded definition may request per diem rate adjustments in accordance with this subsection. The per diem rate increase will result in a corresponding reduction in the direct Medicaid payment.*

(a) *Hospitals which meet the federal definition as a critical access hospital will have a per diem rate equal to one hundred percent (100%) of their estimated MO HealthNet cost per day as determined in 13 CSR 70-15.015.*

(b) *Hospitals which meet the Missouri expanded definition as a critical access hospital will have a per diem rate equal to seventy-five percent (75%) of their estimated MO HealthNet cost per day as determined in 13 CSR 70-15.015. This includes new hospitals meeting the Missouri expanded definition as a critical access hospital whose interim MO HealthNet rate was calculated in accordance with subsection 13 CSR 70-15.015.*

3. The following will not be subject to review under these procedures:

- A. The use of Medicare standards and reimbursement principles;
- B. The method for determining the trend factor;
- C. The use of all-inclusive prospective reimbursement rates; and

D. *Increased costs for the successor owner, management, or leaseholder that result from changes in ownership, management, control, operation, or leasehold interests by whatever form for any hospital previously certified at any time for participation in the MO HealthNet program, except a review may be conducted when a hospital changes from nonprofit to proprietary or vice versa to recognize the*

*change in its property taxes, see paragraph (5)(E)4.*

4. As a condition of review, the MO HealthNet Division may require the hospital to submit to a comprehensive operational review. The review will be made at the discretion of the MO HealthNet Division and may be performed by it or its designee. The findings from any such review may be used to recalculate allowable costs for the hospital.

5. The request for an adjustment must be submitted in writing to the MO HealthNet Division and must specifically and clearly identify the issue and the total dollar amount involved. The total dollar amount must be supported by generally acceptable accounting principles. The hospital shall demonstrate the adjustment is necessary, proper, and consistent with efficient and economical delivery of covered patient care services. The hospital will be notified in writing of the agency's decision within sixty (60) days of receipt of the hospital's written request or within sixty (60) days of receipt of any additional documentation or clarification which may be required, whichever is later. Failure to submit requested information within the sixty- (60-) day period shall be grounds for denial of the request. If the state does not respond within the sixty- (60-) day period, the request shall be deemed denied.

(G) *Sanctions.* Sanctions may be imposed against a provider in accordance with 13 CSR 70-3.030 and other applicable state and federal regulations.

(6) *Outlier Adjustment for Children Under the Age of Six (6).*

(A) *Effective for admissions beginning on or after July 1, 1991, outlier adjustments for medically necessary inpatient services involving exceptionally high cost or exceptionally long lengths of stay for MO HealthNet-eligible children under the age of six (6) will be made to hospitals meeting the criteria under this plan and, for MO HealthNet-eligible infants under the age of one (1), will be made to any other MO HealthNet hospital except for specialty pediatric hospitals.*

1. The following criteria must be met to be eligible for outlier adjustments for children one (1) year of age to children under six (6) years of age:

A. *If the facility offered nonemergency obstetric services as of December 21, 1987, there must be at least two (2) obstetricians with staff privileges at the hospital who have agreed to provide obstetric services to individuals entitled to these services under the Missouri Medicaid plan. In the case of a hospital located in a rural area (area outside of a metropolitan statistical area, as defined by the federal Executive Office of Management and Budget), the term obstetrician includes any physician with staff privileges at the hospital to perform nonemergency obstetric procedures. This section does not apply to hospitals either with inpatients predominantly under eighteen (18) years of age or which did not offer nonemergency obstetric services as of December 21, 1987;*

B. *As determined from the fourth prior year desk-reviewed cost report, the facility must have either—*

(I) *A Medicaid inpatient utilization rate (MIUR) at least one (1) standard deviation above the state's mean MIUR for all Missouri hospitals. The MIUR will be expressed as the ratio of total Medicaid days (TMD) provided under a state plan divided by the provider's total number of inpatient days (TNID). The state's mean MIUR will be expressed as the ratio of the sum of the total number of the Medicaid days for all Missouri hospitals divided by the sum of the total patient days for the same Missouri hospitals. Data for hospitals no longer participating in the program will be excluded;*

$$MIUR = \frac{TMD}{TNID}$$



or

(II) A low-income utilization rate (LIUR) in excess of twenty-five percent (25%). The LIUR shall be the sum (expressed as a percentage) of the fractions, calculated as follows:

(a) Total MO HealthNet patient revenues (TMPR) paid to the hospital for patient services under a state plan plus the amount of the cash subsidies (CS) directly received from state and local governments, divided by the total net revenues (TNR) (charges, minus contractual allowances, discounts, and the like) for patient services plus the CS; and

(b) The total amount of the hospital's charges for patient services attributable to charity care (CC) (care provided to individuals who have no source of payment, third-party, or personal resources) less CS directly received from state and local governments in the same period, divided by the total amount of the hospital's charges (THC) for patient services. The total patient charges attributed to CC shall not include any contractual allowances and discounts other than for indigent patients not eligible for MO HealthNet under a state plan;

$$LIUR = \frac{TMPR + CS}{TNR + CS} + \frac{CC - CS}{THC}$$

C. As determined from the fourth prior year desk-reviewed cost report, the hospital—

(I) Has an unsponsored care ratio of at least ten percent (10%). The unsponsored care ratio is determined as the sum of bad debts and CC divided by TNR and also meets either of the criteria in subparagraph (6)(A)1.B.; or

(II) Ranks in the top fifteen (15) in the number of Medicaid inpatient days provided by that hospital compared to Medicaid patient days provided by all hospitals, and the hospitals also have a Medicaid nursery utilization ratio greater than thirty-five percent (35%) as computed by dividing Title XIX nursery and neonatal days by total nursery and neonatal days; or

(III) Operated a neonatal intensive care unit with a ratio of Missouri Medicaid neonatal patient days to Missouri Medicaid total patient days in excess of nine percent (9%) reported or verified by the division from the fourth prior year cost report;

D. As determined from the fourth prior year desk-reviewed cost report—

(I) The acute care hospital has an unsponsored care ratio of at least sixty-five percent (65%) and is licensed for less than fifty (50) inpatient beds; or

(II) The acute care hospital has an unsponsored care ratio of at least sixty-five percent (65%) and is licensed for fifty (50) inpatient beds or more and has an occupancy rate of more than forty percent (40%); or

(III) The hospital is owned or operated by the Board of Curators as defined in Chapter 172, RSMo, or their successors; or

(IV) The hospital is a public hospital operated by the Department of Mental Health primarily for the care and treatment of mental disorders; and

E. As determined from the fourth prior year desk-reviewed cost report, hospitals which annually provide more than five thousand (5,000) Title XIX days of care and whose Title XIX nursery days represent more than fifty percent (50%) of the hospital's total nursery days.

2. The following criteria must be met for the services to be eligible for outlier review:

A. The patient must be a MO HealthNet-eligible infant under the age of one (1) year, or for hospitals that meet the criteria under paragraph (6)(A)1. a MO HealthNet-eligible child under the age of six (6) years, for all dates of service

presented for review;

B. Hospitals requesting outlier review for children one (1) year of age to children under six (6) years of age must have qualified under paragraph (6)(A)1. for the state fiscal year corresponding with the fiscal year end of the cost report referred to in paragraph (6)(A)6.; and

C. One (1) of the following conditions must be satisfied:

(I) The total reimbursable charges for dates of service [as described in paragraph (6)(A)4. must be at least one hundred fifty percent (150%) of the sum of total third-party liabilities and MO HealthNet inpatient claim payments for that claim; or

(II) The dates of service must exceed sixty (60) days and less than seventy-five percent (75%) of the total service days was reimbursed by MO HealthNet.

3. Claims for all dates of service eligible for outlier review must—

A. Have been submitted to the MO HealthNet Division fiscal agent or the managed care health plan in their entirety for routine claims processing, and claim payment must have been made before the claims are submitted to the division for outlier review; and

B. Be submitted for outlier review with all documentation as required by the MO HealthNet Division no later than ninety (90) days from the last payment made by the fiscal agent or the managed care health plan through the normal claims processing system for those dates of service.

4. Information for outlier reimbursement processing will be determined from claim charges and MO HealthNet payment data, submitted to the MO HealthNet Division fiscal agent or managed care health plan, by the hospital through normal claim submission. If the claim information is determined to be incomplete as submitted, the hospital may be asked to provide claim data directly to the MO HealthNet Division for outlier review.

5. The claims may be reviewed for—

A. Medical necessity at an inpatient hospital level-of-care;

B. Appropriateness of services provided in connection with the diagnosis;

C. Charges that are not permissible per the MO HealthNet Division; policies established in the hospital provider manual and hospital bulletins; and

D. If the hospital is asked to provide claim information, the hospital will need to provide an affidavit vouching to the accuracy of final payments by the MO HealthNet Division, managed care health plans, and other third-party payors. The calculation of outlier payments will be based on the standard hospital payment defined in subparagraph (6)(A)7.B.

6. After the review, reimbursable costs for each claim will be determined using the following data from the most recent Medicaid hospital cost report filed by June 1 of each year:

A. Average routine (room and board) costs for the general and special care units for all days of the stay eligible per the outlier review;

B. Ancillary cost-to-charge ratios applied to claim ancillary charges determined eligible for reimbursement per the outlier review; and

C. No cost will be calculated for items such as malpractice insurance premiums, interns and residents, professional services, or return on equity.

7. Each state fiscal year, outlier adjustment payments for each hospital will be made for all claims submitted before March 1 of the preceding state fiscal year which satisfy all conditions in paragraphs (6)(A)1.-5. The payments

will be determined for each hospital as follows:

A. Sum all reimbursable costs per paragraph (6)(A)6. for all applicable outlier claims to equal total reimbursable costs;

B. For those claims, subtract third-party payments and MO HealthNet payments, which includes both per diem payments and Direct Medicaid Add-On payments, from total reimbursable costs to equal excess cost; and

C. Multiply excess costs by fifty percent (50%).

(B) Effective for admissions beginning on or after July 1, 1997, outlier adjustments shall also be made for MO HealthNet participants enrolled in managed care. All criteria listed under subsection (6)(A) applies to managed care outlier submissions.

(C) Effective for admissions beginning on or after May 1, 2017, outlier adjustments will only be made for the fee for service claims. All criteria listed under subsection (6)(A) will continue to be applied to the fee for service outlier submissions.]

(C) Cost report audits.

1. The examination or inspection of a hospital's cost report, files, and any other supporting documentation by the division or its authorized contractor. The division or its authorized contractor may perform the following types of audits:

A. Level I audit—Requires a more narrow scope of review of hospital cost reports, files, and any other additional information requested and submitted to the division or its authorized contractor. The limited review may include items such as comparative analysis of a hospital's cost report data to industry data, a review of a hospital's prior year data to determine any outliers that may warrant further review, requesting additional details of the reported information, all of which could lead to potential adjustment(s) after such further review, as well as making standard adjustments, etc. Level I audits may be provided off-site;

B. Level II audit—Requires a desk review of hospital cost reports, files, and any other additional information requested and submitted to the division or its authorized contractor. The desk review may include review procedures in a level I audit plus a more detailed analysis of a hospital's cost report data to identify items that would require further review including requesting additional details of the reported information, documentation to support amounts reflected in the cost report, etc. Level II audits may be provided off-site; or

C. Level III audits—Requires an in depth audit, including an on-site review, of hospital cost reports, files, and any other additional information requested and submitted to the division or its authorized contractor. The level III audit will require an in depth analysis of a hospital's cost report data and an on-site verification of cost report items deemed necessary through a risk assessment or other analyses, etc. Level III audits will require some portion of the hospital's records review be provided on-site.

(4) Inpatient *Per Diem* Reimbursement Rate Computation. Effective for dates of service beginning July 1, 2022, each Missouri hospital shall receive a Missouri Medicaid *per diem* rate based on the following computation:

(A) The *per diem* shall be determined from the base year cost report in accordance with the following formula:

$$PER\ DIEM = ((TAC / MPD) * TI) + MIP\ FRA$$

1. MIP FRA—Medicaid inpatient share of FRA. The Medicaid inpatient share of the FRA Assessment will be calculated by dividing the hospital's Medicaid patient days from the base year cost report by total hospital patient days from the base year cost report to arrive at the Medicaid utilization percentage. This percentage is then multiplied by the inpatient FRA assessment for the current SFY to arrive at the increased allowable Medicaid

cost. This cost is then divided by the estimated Medicaid days for the current SFY to arrive at the increased Medicaid cost per day;

2. MPD—Medicaid inpatient days from the base year cost report;

3. TI—Trend indices. The trend indices are applied to the TAC per day of the *per diem* rate. The trend index for the base year is used to adjust the TAC per day to a common fiscal year end of June 30. The adjusted TAC per day shall be trended through the current SFY;

4. TAC—Medicaid allowable inpatient routine and special care unit costs, and ancillary costs, from the base year cost report, will be added to determine the hospital's Medicaid total allowable cost (TAC);

5. The *per diem* for private free-standing psychiatric hospitals shall be the greater of one-hundred percent (100%) of the SFY 2022 weighted average statewide *per diem* rate for private free-standing psychiatric hospitals or the *per diem* as calculated in subsection (4)(A);

6. The *per diem* shall not exceed the average Medicaid inpatient charge *per diem* as determined from the base year cost report and adjusted by the TI;

7. The *per diem* shall be adjusted for rate increases granted in accordance with subsections (4)(C) and (4)(D);

8. If the hospital does not have a base year cost report, the inpatient *per diem* will be the weighted average statewide *per diem* rate as determined in section (5);

(B) Trend indices (TI). For trend indices for State Fiscal Year (SFY) 2018 and forward, refer to the Hospital Market Basket index as published in Healthcare Cost Review by Institute of Health Systems (IHS), or equivalent publication, regardless of any changes in the name of the publication or publisher, for each SFY;

(C) Adjustments to rates. A hospital's inpatient *per diem* rate may be adjusted only under the following circumstances:

1. When information contained in the cost report is found to be intentionally misrepresented. Such adjustment shall be made retroactive to the date of the original rate. Such adjustment shall not preclude the division from imposing any sanctions authorized by any statute or regulation; and

2. When a rate reconsideration is granted in accordance with subsection (4)(D);

(D) Rate reconsideration.

1. Rate reconsideration may be requested under this subsection for changes in allowable costs which occur subsequent to the base year cost report described in subsection (4)(A). The effective date for any increase granted under this subsection shall be no earlier than the first day of the month following the division's final determination of the rate reconsideration.

2. The following may be subject to review under procedures established by the division:

A. New or expanded inpatient services. A hospital, at times, may offer to the public new or expanded inpatient services which may require certificate of need (CON) approval.

(I) A state hospital, i.e., one owned or operated by the Board of Curators as provided for in Chapter 172, RSMo, or one owned or operated by the Department of Mental Health, may offer new or expanded inpatient services to the public provided it receives legislative appropriations for the project. A state hospital may submit a request for inpatient rate reconsideration if the project meets or exceeds a cost threshold of one (1) million dollars for capital expenditures or one (1) million dollars for major medical equipment expenditures as described in 19 CSR 60-50.300.

(II) Non-state hospitals, may also offer new or expanded inpatient services to the public, and incur costs associated with the additions or expansions which may qualify for inpatient rate reconsideration requests. Such projects may require a CON. Rate reconsideration requests for projects requiring CON review

must include a copy of the CON program approval. Non-state hospitals may request inpatient rate reconsiderations for projects not requiring review by the CON program, provided each project meets or exceeds a cost threshold of one (1) million dollars for capital expenditures as described in 19 CSR 60-50.300.

(III) A hospital (state or non-state) will have six (6) months after the new or expanded service project is completed and the service is offered to the public to submit a request for inpatient rate reconsideration, along with a budget of the project's costs. The rate reconsideration request and budget will be subject to review. Upon completion of the review, the hospital's inpatient reimbursement rate may be adjusted, if indicated. Failure to submit a request for rate reconsideration and project budget within the six- (6-) month period shall disqualify the hospital from receiving a rate increase prior to recognizing the increase through the trended cost calculation.

(IV) Rate reconsiderations due to new or expanded services will be determined as total allowable project cost (i.e., the sum of annual depreciation, annualized interest expense, and annual additional operating costs) multiplied by the ratio of total inpatient costs (less SNF and swing bed cost) to total hospital cost as submitted on the most recent cost report filed with the division or its authorized contractor as of the review date divided by total acute care patient days including all special care units and nursery, but excluding swing bed days. The most recent cost report filed must be audited prior to the finalization of the rate reconsideration.

(V) Total acute care patient days (excluding nursery and swing bed days) must be at least sixty percent (60%) of total possible bed days. Total possible bed days will be determined using the number of licensed beds times three hundred sixty-five (365) days. If the total acute care patient days (excluding nursery and swing bed days) are less than sixty percent (60%) of total possible bed days, the sixty percent (60%) number plus nursery days will be used to determine the rate increase. If the total acute care patient days (excluding nursery and swing bed days) are at least sixty percent (60%) of total possible bed days, the total acute care patient days plus nursery days will be used to determine the rate increase. This computation will apply to capital costs only.

(VI) Major medical equipment costs included in rate reconsideration requests shall not include costs to replace current major medical equipment if the replacement does not result in new or expanded inpatient services. The replacement of inoperative or obsolete major medical equipment, by itself, does not qualify for rate reconsideration, even if the new equipment costs at least one (1) million dollars; and

B. When the hospital experiences extraordinary circumstances which may include but are not limited to an act of God, war, or civil disturbance.

3. The following will not be subject to review under these procedures:

A. The use of Medicare standards and reimbursement principles;

B. The method for determining the trend factor;

C. The use of all-inclusive prospective reimbursement rates; and

D. Increased costs for the successor owner, management or leaseholder that result from changes in ownership, management, control, operation, or leasehold interests by whatever form for any hospital previously certified at any time for participation in the Medicaid program.

4. The request for a rate reconsideration must be submitted in writing to the division and must specifically and clearly identify the project and the total dollar amount involved. The total dollar amount must be supported by generally accepted accounting principles. The hospital shall demonstrate the rate reconsideration is necessary, proper, and consistent with efficient and economical delivery of covered patient care services. The hospital

will be notified of the division's decision in writing within sixty (60) days of receipt of the hospital's written request or within sixty (60) days of receipt of any additional documentation or clarification which may be required, whichever is later. Failure to submit requested information within the sixty (60) day period, shall be grounds for denial of the request.

(5) *Per Diem* Reimbursement Rate Computation for New Hospitals. Effective for dates of service beginning July 1, 2022, each new Missouri hospital's rate setting cost report shall be the first full fiscal year cost report, which includes inpatient Medicaid costs, otherwise the hospital shall continue to receive the weighted average statewide *per diem* rate as determined below.

(A) Acute care hospitals. In the absence of adequate cost data, a new hospital's Medicaid rate shall be one-hundred percent (100%) of the weighted average statewide *per diem* rate for acute care hospitals until a prospective rate is determined on the hospital's rate setting cost report, in accordance with section (4).

(B) Free-standing psychiatric hospitals. In the absence of adequate cost data, a new hospital's Medicaid rate shall be one hundred percent (100%) of the weighted average statewide *per diem* rate for free-standing psychiatric hospitals, excluding the state psychiatric hospitals, until a prospective rate is determined on the hospital's rate setting cost report, in accordance with section (4).

(C) Long term acute care hospitals. In the absence of adequate cost data, a new hospital's Medicaid rate shall be one hundred percent (100%) of the weighted average statewide *per diem* rate for long term acute care hospitals until a prospective rate is determined on the hospital's rate setting cost report, in accordance with section (4).

(D) Rehabilitation hospitals. In the absence of adequate cost data, a new hospital's Medicaid rate shall be one hundred percent (100%) of the weighted average statewide *per diem* rate for rehabilitation hospitals until a prospective rate is determined on the hospital's rate setting cost report, in accordance with section (4).

(6) Acuity Adjustment Payment (AAP).

(A) Beginning with SFY 2023, hospitals that meet the requirements set forth below shall receive an AAP. Ownership type of the hospital is determined based on the type of control reported on Schedule S-2, Part I, Line 21, Column 1 of the hospital's base year cost report. For purposes of this section, Medicaid payments received shall include the following payments:

1. For SFY 2022, the Medicaid *per diem* payments, direct Medicaid payments, GME payments, and CO payments;

2. For SFY 2023 and forward, the Medicaid *per diem* payments, AAP, PC payment, SLP, GME payments, and CO payments.

(B) Private ownership. A hospital shall receive an AAP if the hospital's MO HealthNet case mix index is greater than a threshold set annually by the division. The preliminary AAP is calculated by multiplying the hospital's MO HealthNet case mix index times the estimated Medicaid payments for the coming SFY. If the hospital's estimated Medicaid payments for the coming SFY plus the preliminary AAP exceeds the hospital's prior SFY Medicaid payments received by a stop-gain percentage, the preliminary AAP will be reduced so the estimated Medicaid payments for the coming SFY plus the final AAP is equal to the stop-gain percent of the hospital's prior SFY Medicaid payments received. If no reduction is necessary, the preliminary AAP shall be considered final.

(C) Non-state government owned or operated (NSGO) ownership. A hospital shall receive an AAP if the hospital's MO HealthNet case mix index is greater than a threshold set annually by the division. The preliminary AAP is calculated by multiplying

the hospital's MO HealthNet case mix index times the estimated Medicaid payments for the coming SFY. If the hospital's estimated Medicaid payments for the coming SFY plus the preliminary AAP exceeds the hospital's prior SFY Medicaid payments received by a stop-gain percentage, the preliminary AAP will be reduced so the estimated Medicaid payments for the coming SFY plus the final AAP is equal to the stop-gain percent of the hospital's prior SFY Medicaid payments received. If no reduction is necessary the preliminary AAP shall be considered final.

(D) The annual final AAP will be calculated for each hospital at the beginning of each SFY. The annual amount will be paid out over the number of financial cycles during the SFY.

**(7) Poison Control (PC) Payment.**

(A) The PC payment shall be determined for hospitals which operated a poison control center during the base year and which continues to operate a poison control center. The PC payment shall reimburse the hospital for the Medicaid share of the total poison control cost and shall be determined as follows:

1. The total poison control cost from the base year cost report will be divided by the total hospital days from the base year cost report to determine a cost per day. This cost per day will then be multiplied by the estimated days for the SFY for which the PC payment is being calculated; and

2. The annual final PC payment will be calculated for each eligible hospital at the beginning of each SFY. The annual amount will be paid out over the number of financial cycles during the SFY.

**(8) Stop Loss Payment (SLP).**

(A) Beginning with SFY 2023 hospitals that meet the requirements set forth below shall receive a SLP. Ownership type of the hospital is determined based on the type of control reported on Schedule S-2, Part I, Line 21, Column 1 of the hospital's base year cost report. For purposes of this section, Medicaid payments received shall include the following payments:

1. For SFY 2022, the Medicaid *per diem* payments, Direct Medicaid payments, GME payments, and CO payments; and

2. For SFY 2023 and forward, the Medicaid *per diem* payments, AAP, PC payment, SLP, GME payments, and CO payments.

(B) Private ownership. Total estimated Medicaid payments for the coming SFY for each hospital shall include any final AAP and PC payment. The total estimated Medicaid payments for each hospital shall be subtracted from the hospital's prior SFY Medicaid payments received then summed to calculate a total increase or decrease in payments for the entire private ownership group. A positive result represents a decrease in payments and a negative amount represents an increase in payments. If the result is a decrease in total payments to the private ownership group, this amount shall represent the total stop loss amount.

1. SLP will be made if a total stop loss amount was calculated in subsection (8)(B). Each hospital that shows a decrease in Medicaid payments shall receive a SLP in the amount of the decrease in payments unless the sum of each hospital's SLP is greater than the total stop loss amount. If the sum is greater than the total stop loss amount, each hospital's SLP shall be calculated by multiplying the total stop loss amount times the ratio of the hospital's decrease in Medicaid payments to the total stop loss amount.

(C) NSGO ownership. Total estimated Medicaid payments for the coming SFY for each hospital shall include any final AAP and PC payment. The total estimated Medicaid payments for each hospital shall be subtracted from the hospital's prior SFY Medicaid payments received then summed to calculate a total increase or decrease in payments for the entire NSGO ownership group. A positive result represents a decrease in payments and a negative amount represents an increase in payments. If the

result is a decrease in total payments to the NSGO ownership group, this amount shall represent the total stop loss amount.

1. SLP will be made if a total stop loss amount was calculated in subsection (8)(C). Each hospital that shows a decrease in Medicaid payments shall receive a SLP in the amount of the decrease in payments unless the sum of each hospital's SLP is greater than the total stop loss amount. If the sum is greater than the total stop loss amount, each hospital's SLP shall be calculated by multiplying the total stop loss amount times the ratio of the hospital's decrease in Medicaid payments to the total stop loss amount.

(D) The annual SLP will be calculated for each hospital at the beginning of each SFY. The annual amount will be paid out over the number of financial cycles during the SFY.

**(9) Medicaid Graduate Medical Education (GME) Payments.** Effective beginning with SFY 2023, a GME payment calculated as the sum of the intern and resident based GME payment and the GME stop loss payment, shall be made to any acute care hospital that provides graduate medical education.

(A) Intern and resident (I&R) based GME payment. The I&R based GME payment will be based on the per I&R Medicaid allocated GME costs not to exceed a maximum amount per I&R. The division will determine the number of full time equivalent (FTE) I&Rs. Total GME costs will be determined using Worksheet A of the base year cost report adjusted by the trend index. Total GME costs is multiplied by the ratio of Medicaid days to total days to determine the Medicaid allocated GME costs which is then divided by the number of FTE I&Rs to calculate the Medicaid allocated cost per I&R. The I&R based GME payment is calculated as the number of FTE I&Rs multiplied by the minimum established by the division or the Medicaid allocated cost per I&R.

(B) GME stop loss payment. The total I&R based GME payment for each hospital shall be subtracted from the hospital's prior SFY GME payments received then summed to calculate a total increase or decrease in payments for the entire group of hospitals that provide graduate medical education. A positive result represents a decrease in payments and a negative amount represents an increase in payments. If the result is a decrease in total payments to the hospitals this amount shall represent the total GME stop loss amount. GME stop loss payments will be made if a total GME stop loss payment amount was calculated in the paragraph above. Each hospital that shows a decrease in GME Medicaid payments shall receive a GME stop loss payment in the amount of the decrease in payments unless the sum of each hospital's GME stop loss payment is greater than the total GME stop loss amount. If the sum is greater than the total GME stop loss amount, each hospital's GME stop loss payment shall be calculated by multiplying the total GME stop loss amount times the ratio of the hospital's decrease in GME Medicaid payments to the total GME stop loss amount.

(C) Hospitals who implement a GME program prior to July 1 of the SFY and do not have a base year cost report to determine GME costs shall receive an I&R based GME payment based on the statewide average per resident amount (PRA) determined as follows:

1. The number of FTE I&Rs shall be reported to the division by June 1 prior to the beginning of the SFY in order to have a GME payment calculated; and

2. The I&R based GME payment shall be calculated as the number of FTE I&Rs multiplied by the Medicaid capped statewide average PRA. The Medicaid capped statewide average PRA is calculated as follows:

A. By applying a straight average to the list of facility PRA's with the following criteria:

(I) A facility's PRA used in the straight average shall be the minimum as established by the division or the facility's actual

**PRA.**

(D) The hospital's I&R based GME payment plus GME stop loss payment, if applicable, will be calculated for each hospital at the beginning of each SFY. The annual amount will be paid on a quarterly basis during the SFY.

**(10) Children's Outlier (CO) Payment—**

(A) The outlier year is based on a discharge date between July 1 and June 30;

(B) Beginning July 1, 2022, for fee-for-service claims only, outlier payments for medically necessary inpatient services involving exceptionally high cost or exceptionally long lengths of stay for MO HealthNet-eligible children under the age of six (6) will be made to hospitals meeting the federal DSH requirements in paragraph (10)(B)1. and for MO HealthNet-eligible infants under the age of one (1) will be made to any other Missouri Medicaid hospital.

1. The following criteria must be met to be eligible for outlier payments for children one (1) year of age to children under six (6) years of age:

A. If the facility offered nonemergency obstetric services as of December 21, 1987, there must be at least two (2) obstetricians with staff privileges at the hospital who have agreed to provide obstetric services to individuals entitled to these services under the Missouri Medicaid plan. In the case of a hospital located in a rural area (area outside of a metropolitan statistical area, as defined by the federal Executive Office of Management and Budget), the term obstetrician includes any physician with staff privileges at the hospital to perform nonemergency obstetric procedures. This section does not apply to hospitals either with inpatients predominantly under eighteen (18) years of age or which did not offer nonemergency obstetric services as of December 21, 1987;

B. As determined from the base year audited Medicaid cost report, the hospital must have either—

(I) A Medicaid inpatient utilization rate (MIUR) at least one (1) standard deviation above the state's mean MIUR for all Missouri hospitals. The MIUR will be expressed as the ratio of total Medicaid days (TMD) provided under a state plan divided by the provider's total number of inpatient days (TNID). The state's mean MIUR will be expressed as the ratio of the sum of the total number of the Medicaid days for all Missouri hospitals divided by the sum of the total patient days for the same Missouri hospitals. Data for hospitals no longer participating in the program will be excluded;

$$\text{MIUR} = \text{TMD} / \text{TNID}$$

or

(II) A low-income utilization rate (LIUR) in excess of twenty-five percent (25%). The LIUR shall be the sum (expressed as a percentage) of the fractions, calculated as follows:

(a) Total MO HealthNet patient revenues (TMPR) paid to the hospital for patient services under a state plan plus the amount of the cash subsidies (CS) directly received from state and local governments, divided by the total net revenues (TNR) (charges, minus contractual allowances, discounts, and the like) for patient services plus the CS; and

(b) The total amount of the hospital's charges for patient services attributable to charity care (CC) less CS directly received from state and local governments in the same period, divided by the total amount of the hospital's charges (THC) for patient services. The total patient charges attributed to CC shall not include any contractual allowances and discounts other than for indigent patients not eligible for MO HealthNet under a state plan.

$$\text{LIUR} = ((\text{TMPR} + \text{CS}) / (\text{TNR} + \text{CS})) + ((\text{CC} - \text{CS}) / \text{THC})$$

2. The following criteria must be met for the services to be eligible for outlier review:

A. The patient must be a MO HealthNet-eligible infant under the age of one (1) year, or for hospitals that meet the federal DSH requirements, a MO HealthNet-eligible child under the age of six (6) years, as of the date of discharge; and

B. One (1) of the following conditions must be satisfied:

(I) The total reimbursable charges for dates of service must be at least one hundred fifty percent (150%) of the sum of claim payments for each claim; or

(II) The dates of service must exceed sixty (60) days and less than seventy-five percent (75%) of the total service days were reimbursed by MO HealthNet.

3. Claims eligible for outlier review must—

A. Have been submitted in their entirety for claims processing; and

B. The claim must have been paid; and

C. An annual outlier file, for paid claims only, must be submitted to the division no later than December 31 of the second calendar year following the end of the outlier year (i.e., claims for outlier year 2022 are due no later than December 31, 2024).

4. After the review, reimbursable costs for each claim will be determined using the following data from the audited Medicaid hospital cost report for the year ending in the same calendar year as the outlier year (i.e., Medicaid hospital cost reports ending in 2022 will be used for the 2022 outlier year):

A. Average routine (room and board) costs for the general and special care units for all days of the stay eligible per the outlier review; and

B. Ancillary cost-to-charge ratios applied to claim ancillary charges determined eligible for reimbursement per the outlier review.

5. The outlier payments will be determined for each hospital as follows:

A. Sum all reimbursable costs for all eligible outlier claims to equal total reimbursable costs;

B. Subtract total claim payments, which includes MO HealthNet claims payments, third-party payments, and co-pays, from total reimbursable costs to equal excess cost; and

C. Multiply excess costs by fifty percent (50%).

**(11) Safety Net Hospitals.**

(A) Inpatient hospital providers may qualify as a safety net hospital based on the following criteria. Hospitals shall qualify for a period of only one (1) SFY and must requalify at the beginning of each SFY to continue their safety net hospital designation.

1. If the facility offered non-emergency obstetric services as of December 21, 1987, there must be at least two (2) obstetricians with staff privileges at the hospital who have agreed to provide obstetric services to individuals entitled to those services under the Missouri Medicaid plan. In the case of a hospital located in a rural area (area outside of a metropolitan statistical area, as defined by the federal executive Office of Management and Budget), the term obstetrician includes any physician with staff privileges at the hospital to perform non-emergency obstetric procedures. This section does not apply to hospitals either with inpatients predominantly under eighteen (18) years of age or which did not offer non-emergency obstetric services as of December 21, 1987;

2. As determined from the audited base year cost report, the facility must have either—

A. A Medicaid inpatient utilization rate (MIUR) at least one (1) standard deviation above the state's mean MIUR for all Missouri hospitals. The MIUR will be expressed as the ratio of total Medicaid days (TMD) (including such patients who receive benefits through a managed care entity) provided under a state plan divided by the provider's total number of inpatient days

(TNID). The state's mean MIUR will be expressed as the ratio of the sum of the total number of Medicaid days for all Missouri hospitals divided by the sum of the total patient days for the same Missouri hospitals. Data for hospitals no longer participating in the program will be excluded. The state's mean MIUR will be expressed as the ratio of the sum of all Medicaid participating hospitals' MIURs divided by the total number of Medicaid participating hospitals for a state plan year;

$$\text{MIUR} = \text{TMD} / \text{TNID}$$

or

B. A low income utilization rate in excess of twenty-five percent (25%).

(I) The low-income utilization rate (LIUR) shall be the sum (expressed as a percentage) of the fractions, calculated as follows:

(a) Total Medicaid patient revenues (TMPR) paid to the hospital for patient services under a state plan (regardless of whether the services were furnished on a fee-for-service basis or through a managed care entity) plus the amount of the cash subsidies (CS) directly received from state and local governments, divided by the total net revenues (TNR) (charges, minus contractual allowances, discounts, etc.) for patient services plus the cash subsidies; and

(b) The total amount of the hospital's charges for patient services attributable to charity care (CC) less cash subsidies directly received from state and local governments in the same period, divided by the total amount of the hospital's charges (THC) for patient services. The total patient charges attributed to charity care shall not include any contractual allowances and discounts other than for indigent patients not eligible for medical assistance under a state plan.

$$\text{LIUR} = ((\text{TMPR} + \text{CS}) / (\text{TNR} + \text{CS})) + ((\text{CC} - \text{CS}) / \text{THC})$$

3. As determined from the audited base year cost report—

A. The acute care hospital has an unsponsored care ratio of at least sixty-five percent (65%) and is licensed for less than fifty (50) inpatient beds; or

B. The acute care hospital has an unsponsored care ratio of at least sixty-five percent (65%) and is licensed for fifty (50) inpatient beds or more and has an occupancy rate of more than forty percent (40%); or

C. A public non-state governmental acute care hospital with an LIUR of at least forty percent (40%) and an MIUR greater than one (1) standard deviation from the mean, and is licensed for fifty (50) inpatient beds or more and has an occupancy rate of at least forty percent (40%); or

D. The hospital is owned or operated by the Board of Curators as defined in Chapter 172, RSMo; or

E. The hospital is a public hospital operated by the Department of Mental Health primarily for the care and treatment of mental disorders.

(12) Hospital Mergers. Hospitals that merge their operations under one Medicare and Medicaid provider number shall have their Medicaid reimbursement combined under the surviving hospital's (the hospital's whose Medicare and Medicaid provider number remained active) Medicaid provider number.

(A) The *per diem* rate for merged hospitals shall be calculated—

1. For the remainder of the SFY in which the merger occurred, the merged rate is calculated by multiplying each hospital's estimated Medicaid paid days by its *per diem* rate, summing the estimated *per diem* payments and estimated Medicaid paid days, and then dividing the total estimated *per diem* payments by the total estimated paid days to determine the weighted

*per diem* rate. The effective date of the weighted *per diem* rate will be the date of the merger; or

2. For subsequent SFYs, the *per diem* rate will be based on the combined data from the base year cost report for each facility.

(B) The Other Medicaid Payments, if applicable, shall be—

1. Combined under the surviving hospital's Medicaid provider number for the remainder of the SFY in which the merger occurred; and

2. Calculated for subsequent SFYs based on the combined data from the base year cost report for each facility.

[(7)](13) Payment Assurance. The state will pay each hospital, which furnishes the services in accordance with the requirements of the state plan, the amount determined for services furnished by the hospital according to the standards and methods set forth in the rules implementing the Hospital Reimbursement Program.

[(8)](14) Inappropriate Placements.

(A) The hospital *[per diem] per diem* rate as determined under this plan and in effect on October 1, 1981, shall not apply to any participant who is receiving inpatient hospital care when *[s/he] the participant* is only in need of nursing home care.

1. If a hospital has an established intermediate care facility/skilled nursing facility (ICF/SNF) or SNF-only MO HealthNet rate for providing nursing home services in a distinct part setting, reimbursement for nursing home services provided in the inpatient hospital setting shall be made at the hospital's ICF/SNF or SNF-only rate.

2. No MO HealthNet payments will be made on behalf of any participant who is receiving inpatient hospital care and is not in need of either inpatient or nursing home care.

[(9) MO HealthNet GME Add-On—A MO HealthNet Add-On determined for Graduate Medical Education (GME) costs shall be allocated based on the estimated effect of implementation of a MO HealthNet managed care system in accordance with this section.

(A) The MO HealthNet GME Add-On for MO HealthNet participants covered under a Managed Care Plan shall be determined using the base year cost report and paid in quarterly installments. The base year cost report shall be the fourth prior fiscal year (i.e., the base year for SFY 1999 is the FY 1995 cost report). The hospital *per diem* shall continue to include a component for GME related to MO HealthNet participants not included in a managed care system.

1. Total GME cost shall be multiplied by a managed care allocation factor which incorporates the estimated percentage of the hospital's MO HealthNet population included in a managed care system and the estimated implementation date for a managed care system. For example: If a hospital has 1) an annual GME cost of one hundred thousand dollars (\$100,000), 2) forty percent (40%) of their MO HealthNet days are related to MO HealthNet participants eligible for MO HealthNet managed care, and 3) the projected implementation date for managed care is October 1, 1995; the prorated GME Add-On is thirty thousand dollars (\$30,000).

2. The annual GME Add-On shall be paid in quarterly installments.

(10) Enhanced Graduate Medical Education (GME) Payment. An enhanced GME payment shall be made to any acute care hospital that provides graduate medical education (teaching hospital).

(A) The enhanced GME payment shall be computed in accordance with subsection (10)(B). The payment shall be made following the end of the state fiscal year. The

enhanced GME payment for each state fiscal year shall be computed using the most recent cost data available when the enhanced GME payment is computed. If the cost report is less than or more than a twelve- (12-) month period, the cost report data will be adjusted to reflect a twelve- (12-) month period. The state share of the enhanced GME payment to a hospital that has cash subsidies shall come from funds certified by the hospital.

(B) The enhanced GME payment will be computed by first determining the percentage difference between the McGraw-Hill CPI index for hospital services and Medicare update factors applied to the per resident amounts from 1986 to the most recent SFY. For example, the percentage difference has been computed to be eighty-five and sixty-two one-hundredth percent (85.62%) for SFY 2000. The percentage difference is then multiplied by the MO HealthNet share of the aggregate approved amount reported on worksheet E-4 of the Medicare cost report (CMS 2552-10) for the fourth prior fiscal year and trended to the current state fiscal year. The resulting product is the enhanced GME payment.

(11) **Hospital Mergers.** Hospitals that merge their operations under one (1) Medicare and MO HealthNet provider number shall have their MO HealthNet reimbursement combined under the surviving hospital's (the hospital whose Medicare and MO HealthNet provider number remains active) MO HealthNet provider number.

(A) The disproportionate share status of the merged hospital provider shall be—

1. The same as the surviving hospital's status was prior to the merger for the remainder of the state fiscal year in which the merger occurred; and

2. Determined based on the combined desk-reviewed data from the appropriate cost reports for the merged hospitals in subsequent fiscal years.

(B) The per diem rate for merged hospitals shall be calculated—

1. For the remainder of the state fiscal year in which the merger occurred by multiplying each hospital's estimated MO HealthNet paid days by its per diem rate, summing the estimated per diem payments and estimated MO HealthNet paid days, and then dividing the total estimated per diem payments by the total estimated paid days to determine the weighted per diem rate. The effective date of the weighted per diem rate will be the date of the merger. This merged rate will also be used in fiscal years following the effective date.

(C) The Direct Medicaid Payments, Uninsured Add-On Payments, and GME payments, if the surviving facility continues the GME program, shall be—

1. Combined under the surviving hospital's MO HealthNet provider number for the remainder of the state fiscal year in which the merger occurred; and

2. Calculated for subsequent state fiscal years based on the combined data from the appropriate cost report for each facility.]

(15) **Directed Payments.** Effective July 1, 2022, the Missouri Medicaid managed care organizations shall make inpatient and outpatient directed payments to in-network hospitals pursuant to 42 CFR 438.6(c) as approved by the Centers for Medicare & Medicaid Services.

**AUTHORITY:** sections 208.153, 208.201, and 660.017, RSMo 2016, and section 208.152, RSMo Supp. [2020] 2021. This rule was previously filed as 13 CSR 40-81.050. Original rule filed Feb. 13, 1969, effective Feb. 23, 1969. For intervening history, please consult the

**Code of State Regulations.** Emergency amendment filed June 14, 2022, effective July 1, 2022, expires Feb. 23, 2023. Amended: Filed June 14, 2022.

**PUBLIC COST: Fee-for-Service:** This proposed amendment is estimated to cost state agencies approximately \$897.4 million (state share: \$302.9 million FRA and \$2.6 million IGT for DMH) for SFY 2023. This proposed amendment is estimated to increase payments to political subdivisions by approximately \$130.6 million for SFY 2023.

**Directed payments:** This proposed amendment is estimated to save state agencies approximately \$19 million (State share: \$6.5 million FRA and \$0 million IGT for DMH) for SFY 2023. This proposed amendment is estimated to cost political subdivisions approximately \$17.5 million for SFY 2023.

**PRIVATE COST: Fee-for-Service:** This proposed amendment is estimated to increase payments to in-state private entities by approximately \$766.8 million for SFY 2023.

**Directed payments:** This proposed amendment is estimated to cost in-state private entities approximately \$1.6 million for SFY 2023.

**NOTICE TO SUBMIT COMMENTS:** Anyone may file a statement in support of or in opposition to this proposed amendment with the Department of Social Services, Legal Services Division-Rulemaking, PO Box 1527, Jefferson City, MO 65102-1527, or by email to [Rules.Comment@dss.mo.gov](mailto:Rules.Comment@dss.mo.gov). To be considered, comments must be received within thirty (30) days after publication of this notice in the *Missouri Register*. A public hearing will not be scheduled.

**FISCAL NOTE  
PUBLIC COST**

- I. **Department Title:** 13 Social Services  
**Division Title:** 70 MO HealthNet Division  
**Chapter Title:** 15 Hospital Program

<b>Rule Number and Name:</b>	13 CSR 70-15.010 Inpatient Hospital Services Reimbursement Methodology
<b>Type of Rulemaking:</b>	Proposed Amendment

**II. SUMMARY OF FISCAL IMPACT**

Affected Agency or Political Subdivision	Estimated Cost of Compliance in the Aggregate
<b>Other Government (Public) &amp; State Hospitals enrolled in MO HealthNet - 38</b>  <b>Department of Social Services, MO HealthNet Division</b>	<b>Fee-For-Service Impacts</b>  <b>Estimated impact for SFY 2023:</b> <b>\$130.6 million</b>  <b>Estimated cost for SFY 2023:</b> <b>Total \$897.4 million;</b> <b>State Share \$302.9 million (FRA)</b> <b>State Share \$2.6 million (IGT)</b>
<b>Other Government (Public) &amp; State Hospitals enrolled in MO HealthNet - 32</b>  <b>Department of Social Services, MO HealthNet Division</b>	<b>Directed Payments Impacts</b>  <b>Estimated cost for SFY 2023:</b> <b>\$17.5 million</b>  <b>Estimated savings for SFY 2023:</b> <b>Total \$19 million;</b> <b>State Share \$6.5 million (FRA)</b> <b>State Share \$0 million (IGT)</b>

**III. WORKSHEET**

<b>Fee-for-Service Impact:</b>			
<b>Other Government (Public) &amp; State Hospitals Impact:</b>			
<b>Estimated Impact for 6 Months of SFY 2023:</b>			
	FRA Fund	IGT Fund	Total
Estimated Impact to State Hospitals	\$36,643,472	\$7,757,025	\$44,400,497
Estimated Impact to Other Government (Public) Hospitals	\$86,153,841	\$0	\$86,153,841
Total Estimated Impact	\$122,797,313	\$7,757,025	\$130,554,338
State Share Percentage	34.0525%	34.0525%	34.0525%
Estimated State Share	\$41,815,555	\$2,641,461	\$44,457,016



<b>Department of Social Services, MO HealthNet Division Cost:</b>			
<b>Estimated Cost for 6 Months of SFY 2023:</b>			
	FRA Fund	IGT Fund	Total
Estimated Cost	\$889,626,168	\$7,757,025	\$897,383,193
State Share Percentage	34.0525%	34.0525%	34.0525%
Estimated State Share Cost	\$302,939,951	\$2,641,461	\$305,581,412

  

<b>Directed Payment Cost:</b>			
<b>Other Government (Public) &amp; State Hospitals Cost:</b>			
<b>Estimated Cost for 6 Months of SFY 2023:</b>			
	FRA Fund	IGT Fund	Total
Estimated Cost to State Hospitals	\$4,084,472	\$0	\$4,084,472
Estimated Cost to Other Government (Public) Hospitals	\$13,392,128	\$0	\$13,392,128
Total Estimated Cost	\$17,476,600	\$0	\$17,476,600
State Share Percentage	34.0525%	34.0525%	34.0525%
Estimated State Share	\$5,951,219	\$0	\$5,951,219

  

<b>Department of Social Services, MO HealthNet Division Savings:</b>			
<b>Estimated Savings for 6 Months of SFY 2023:</b>			
	FRA Fund	IGT Fund	Total
Estimated Savings	\$19,046,694	\$0	\$19,046,694
State Share Percentage	34.0525%	34.0525%	34.0525%
Estimated State Share Savings	\$6,485,875	\$0	\$6,485,875

#### IV. ASSUMPTIONS

The following regulations are impacted by the change to the hospital reimbursement methodology and the impact of all the regulations should be netted to arrive at the total impact. The net impact is a cost to the state of \$7.6 million for SFY 2023.

13 CSR 70-15.010  
13 CSR 70-15.015  
13 CSR 70-15.220  
13 CSR 70-15.230

The fiscal impact is estimated based on historical utilization and enrollment. Other variables such as the length of the Federal Public Health Emergency and Medicaid Expansion enrollment may indirectly affect the hospital utilization both positively and negatively. Due to the uncertainty of these variables, the state will continue to monitor the impacts to the Managed Care Organizations and hospitals.

**FISCAL NOTE  
PRIVATE COST**

- I. **Department Title:** 13 Social Services  
**Division Title:** 70 MO HealthNet Division  
**Chapter Title:** 15 Hospital Program

<b>Rule Number and Title:</b>	13 CSR 70-15.010 Inpatient Hospital Services Reimbursement Methodology
<b>Type of Rulemaking:</b>	Proposed Amendment

**II. SUMMARY OF FISCAL IMPACT**

<b>Estimate of the number of entities by class which would likely be affected by the adoption of the rule:</b>	<b>Classification by types of the business entities which would likely be affected:</b>	<b>Estimate in the aggregate as to the cost of compliance with the rule by the affected entities:</b>
<b>In-State Hospitals – 100</b>	<b>Private Hospitals enrolled in MO HealthNet</b>	<b>FFS Estimated impact for SFY 2023: \$766.8 million</b>
<b>In-State Hospitals - 99</b>	<b>Private Hospitals enrolled in MO HealthNet</b>	<b>Directed Payment Estimated cost for SFY 2023: \$1.6 million</b>

**III. WORKSHEET**

<b><u>Fee-for-Service Impact:</u></b>			
<b><u>In-State Private Hospitals Impact:</u></b>			
<b><u>Estimated Impact for SFY 2023:</u></b>			
	FRA Fund	IGT Fund	Total
Estimated Impact to In-State Private Hospitals	\$766,828,855	\$0	\$766,828,855
State Share Percentage	34.0525%	34.0525%	34.0525%
Estimated State Share	\$261,124,396	\$0	\$261,124,396

<b><u>Directed Payment Impact:</u></b>			
<b><u>In-State Private Hospitals Impact:</u></b>			
<b><u>Estimated Cost for SFY 2023:</u></b>			
	FRA Fund	IGT Fund	Total
Estimated Cost to In-State Private Hospitals	\$1,570,094	\$0	\$1,570,094
State Share Percentage	34.0525%	34.0525%	34.0525%
Estimated State Share	\$534,656	\$0	\$534,656

#### **IV. ASSUMPTIONS**

The following regulations are impacted by the change to the hospital reimbursement methodology and the impact of all the regulations should be netted to arrive at the total impact. The net impact is a cost to the state of \$7.6 million for SFY 2023.

13 CSR 70-15.010

13 CSR 70-15.015

13 CSR 70-15.220

13 CSR 70-15.230

The fiscal impact is estimated based on historical utilization and enrollment. Other variables such as the length of the Federal Public Health Emergency and Medicaid Expansion enrollment may indirectly affect the hospital utilization both positively and negatively. Due to the uncertainty of these variables, the state will continue to monitor the impacts to the Managed Care Organizations and hospitals.

**Title 13—DEPARTMENT OF SOCIAL SERVICES**  
**Division 70—MO HealthNet Division**  
**Chapter 15—Hospital Program**

**PROPOSED AMENDMENT**

**13 CSR 70-15.015 Direct Medicaid Payments.** The division is deleting sections (1) and (2) and adding a new section (1).

*PURPOSE: This amendment provides for the calculation of the Outpatient Direct Medicaid payments made on or after July 1, 2022. The division is removing the calculation of the Inpatient Direct Medicaid Payment.*

*[(1) Direct Medicaid Qualifying Criteria.*

*(A) An inpatient hospital provider may qualify as a Disproportionate Share Hospital (DSH) based on the following criteria. Hospitals shall qualify as a DSH for a period of only one (1) state fiscal year (SFY) and must requalify at the beginning of each SFY to continue their DSH classification.*

*1. If the facility offered nonemergency obstetric services as of December 21, 1987, there must be at least two (2) obstetricians with staff privileges at the hospital who have agreed to provide obstetric services to individuals entitled to these services under the Missouri Medicaid plan. In the case of a hospital located in a rural area (area outside of a metropolitan statistical area, as defined by the federal Executive Office of Management and Budget), the term obstetrician includes any physician with staff privileges at the hospital to perform nonemergency obstetric procedures. This section does not apply to hospitals either with inpatients predominantly under eighteen (18) years of age or which did not offer nonemergency obstetric services as of December 21, 1987.*

*2. As determined from the fourth prior year audited cost report, the facility must have either—*

*A. A Medicaid inpatient utilization rate (MIUR) at least one (1) standard deviation above the state's mean MIUR for all Missouri hospitals. The MIUR will be expressed as the ratio of total Medicaid days (TMD) provided under a state plan divided by the provider's total number of inpatient days (TNID). The state's mean MIUR will be expressed as the ratio of the sum of the total number of the Medicaid days for all Missouri hospitals divided by the sum of the total patient days for the same Missouri hospitals. Data for hospitals no longer participating in the program will be excluded;*

$$MIUR = TMD / TNID$$

*or*

*B. A low-income utilization rate (LIUR) in excess of twenty-five percent (25%). The LIUR shall be the sum (expressed as a percentage) of the fractions, calculated as follows:*

*(I) Total MO HealthNet patient revenues (TMPR) paid to the hospital for patient services under a state plan plus the amount of the cash subsidies (CS) directly received from state and local governments, divided by the total net revenues (TNR) (charges, minus contractual allowances, discounts, and the like) for patient services plus the CS; and*

*(II) The total amount of the hospital's charges for patient services attributable to charity care (CC) (care provided to individuals who have no source of payment, third-party, or personal resources) less CS directly received from state and local governments in the same period, divided by the total amount of the hospital's charges (THC) for patient services. The total patient charges attributed to CC shall not include any contractual allowances and discounts other than for indigent patients not eligible for MO HealthNet under a*

*state plan.*

$$LIUR = ((TMPR + CS) / (TNR + CS)) \\ + ((CC - CS) / (THC))$$

*3. As determined from the fourth prior year audited cost report, the hospital—*

*A. Has an unsponsored care ratio of at least ten percent (10%). The unsponsored care ratio is determined as the sum of bad debts and CC divided by TNR and also meets either of the criteria in paragraph (1)(A)2.; or*

*B. Ranks in the top fifteen (15) in the number of Medicaid inpatient days provided by that hospital compared to Medicaid patient days provided by all hospitals, and the hospitals also have a Medicaid nursery utilization ratio greater than thirty-five percent (35%) as computed by dividing Title XIX nursery and neonatal days by total nursery and neonatal days; or*

*C. Operated a neonatal intensive care unit with a ratio of Missouri Medicaid neonatal patient days to Missouri Medicaid total patient days in excess of nine percent (9%) reported or verified by the division from the fourth prior year cost report.*

*4. As determined from the fourth prior year audited cost report—*

*A. The acute care hospital has an unsponsored care ratio of at least sixty-five percent (65%) and is licensed for less than fifty (50) inpatient beds; or*

*B. The acute care hospital has an unsponsored care ratio of at least sixty-five percent (65%) and is licensed for fifty (50) inpatient beds or more and has an occupancy rate of more than forty percent (40%); or*

*C. A public non-state governmental acute care hospital with an LIUR of at least fifty percent (50%) and an MIUR greater than one (1) standard deviation from the mean, and is licensed for fifty (50) inpatient beds or more and has an occupancy rate of at least forty percent (40%); or*

*D. The hospital is owned or operated by the Board of Curators as defined in Chapter 172, RSMo, or their successors; or*

*E. The hospital is a public hospital operated by the Department of Mental Health primarily for the care and treatment of mental disorders.*

*5. As determined from the fourth prior year audited cost report, hospitals which annually provide more than five thousand (5,000) Title XIX days of care and whose Title XIX nursery days represent more than fifty percent (50%) of the hospital's total nursery days.*

*(B) Those hospitals which meet the criteria established in paragraphs (1)(A)1., (1)(A)2., and (1)(A)4. shall be deemed safety net hospitals. Those hospitals which meet the criteria established in paragraphs (1)(A)1. and (1)(A)3. shall be deemed first tier Disproportionate Share Hospitals (DSH). Those hospitals which meet only the criteria established in paragraphs (1)(A)1. and (1)(A)2. or (1)(A)1. and (1)(A)5. shall be deemed second tier DSH.*

**(2) Direct Medicaid Payments.]**

*(A) Outpatient Direct Medicaid Payments. Outpatient Direct Medicaid payments will be made to hospitals for the following allowable MO HealthNet costs not included in the per diem rate as calculated in 13 CSR 70-15.010(3):*

*1. The increased MO HealthNet costs resulting from the Federal Reimbursement Allowance (FRA) assessment becoming an allowable cost on January 1, 1999;*

*2. The unreimbursed MO HealthNet costs applicable to the trend factor which is not included in the per diem rate;*

*3. The unreimbursed MO HealthNet costs for capital and*

medical education not included in the trended per diem cost as a result of the application of the sixty percent (60%) minimum utilization adjustment in 13 CSR 70-15.010(3)(A)4.;

4. The increased cost per day resulting from the utilization adjustment. The increased cost per day results from lower utilization of inpatient hospital services by MO HealthNet participants now covered by a managed care health plan;

5. The poison control adjustment shall be determined for hospitals which operated a poison control center during the base year and which continues to operate a poison control center in a MO HealthNet managed care region; and

6. The increased cost resulting from including out-of-state Medicaid days in total projected MO HealthNet days.]

(B) The MO HealthNet Division will calculate the Outpatient Direct Medicaid payment as follows:

1. The MO HealthNet share of the inpatient FRA assessment will be calculated by dividing the hospital's inpatient Medicaid patient days by the total inpatient hospital patient days from the hospital's base cost report to arrive at the inpatient Medicaid utilization percentage. This percentage is then multiplied by the inpatient FRA assessment for the current SFY to arrive at the increased allowable MO HealthNet costs for the inpatient FRA assessment. The MO HealthNet share of the outpatient FRA assessment will be calculated by dividing the hospital's outpatient MO HealthNet charges by the total outpatient hospital charges from the base cost report to arrive at the MO HealthNet utilization percentage. This percentage is then multiplied by the outpatient FRA assessment for the current SFY to arrive at the increased allowable MO HealthNet costs for the outpatient FRA assessment.

A. Effective for payments made on or after May 1, 2017, only the Fee-for-Service (FFS) and Out-of-State (OOS) components of the MO HealthNet share of both the inpatient and outpatient FRA assessment will be included in the Direct Medicaid add-on payment;

2. The unreimbursed MO HealthNet costs are determined by subtracting the hospital's per diem rate from its trended per diem costs. The difference is multiplied by the estimated MO HealthNet patient days for the current SFY plus the out-of-state days from the fourth prior year cost report trended to the current SFY. The FFS days are determined from a regression analysis of the hospital's FFS days from February 1999 through December of the second prior SFY. The managed care days are based on the FFS days determined from the regression analysis, as follows: The FFS days are factored up by the percentage of FFS days to the total of FFS days plus managed care days from the hospital's fourth prior year cost report. The difference between the FFS days and the FFS days factored up by the FFS days' percentage are the managed care days.

A. Effective for payments made on or after July 1, 2020, the estimated MO HealthNet patient days for the SFY shall be determined by adjusting the FFS days from the state's Medicaid Management Information System (MMIS) for the second prior calendar year (CY) (i.e., for SFY 2021, second prior CY would be 2019) by—

(I) The trend determined from a quadratic regression analysis of the hospital's FFS days from February 1999 through December of the second prior CY;

(II) The FFS days are factored up by one (1) of the following:

(a) For hospitals that are in a managed care extension region or a psychiatric hospital, the lower of the percentage of FFS days to the total of FFS days plus managed care days from the hospital's fourth prior year cost report or from the hospital's third prior year cost report to

yield the estimated MO HealthNet patient days; or

(b) For hospitals that are not in a managed care extension region or a psychiatric hospital, the percentage of FFS days to the total of FFS days plus managed care days from the hospital's fourth prior year cost report to yield the estimated MO HealthNet patient days; and

(III) The difference between the FFS days and the FFS days factored up by the FFS days' percentage are the managed care days.

B. The trended cost per day is calculated by trending the base year costs per day by the trend indices as defined in 13 CSR 70-15.010(3)(B), using the rate calculation in 13 CSR 70-15.010(3)(A).

C. For hospitals that meet the requirements in paragraphs (1)(A)1., (1)(A)2., and (1)(A)4. of this rule (safety net hospitals), the base year cost report may be from the third, fourth, or fifth prior year. For hospitals that meet the requirements in paragraphs (1)(A)1. and (1)(A)3. of this rule (first tier DSH), the base year cost report may be from the third or fourth prior year. The MO HealthNet Division shall exercise its sole discretion as to which report is most representative of costs. For all other hospitals, the base year cost report is the fourth prior year. For any hospital that has both a twelve- (12-) month cost report and a partial year cost report, its base period cost report for that year will be the twelve- (12-) month cost report.

D. The trended cost per day does not include the costs associated with the FRA assessment, the application of minimum utilization, the utilization adjustment, and the poison control costs computed in paragraphs (2)(B)1., 3., 4., and 5.;

3. The minimum utilization costs for capital and medical education is calculated by determining the difference in the hospital's cost per day when applying the minimum utilization, as identified in 13 CSR 70-15.010(5)(C)4., and without applying the minimum utilization. The difference in the cost per day is multiplied by the estimated MO HealthNet patient days for the SFY;

4. The utilization adjustment cost is determined by estimating the number of MO HealthNet inpatient days the hospital will not provide as a result of the managed care health plans limiting inpatient hospital services. These days are multiplied by the hospital's cost per day to determine the total cost associated with these days. This cost is divided by the remaining total patient days from its base period cost report to arrive at the increased cost per day. This increased cost per day is multiplied by the estimated MO HealthNet patient days for the current SFY to arrive at the MO HealthNet utilization adjustment.

A. Effective July 1, 2011, the utilization adjustment will no longer apply to any hospital other than safety net hospitals as defined in subsection (1)(B), children's hospitals as defined in 13 CSR 70-15.010(2)(Q), and specialty pediatric hospitals as defined in 13 CSR 70-15.010(2)(O). Children's hospitals and specialty pediatric hospitals will continue to receive fifty percent (50%) of the adjustment calculated in accordance with paragraph (2)(B)4. Safety net hospitals will continue to receive one hundred percent (100%) of the adjustment calculated in accordance with paragraph (2)(B)4.;

5. The poison control cost shall reimburse the hospital for the prorated MO HealthNet managed care cost. It will be calculated by multiplying the estimated MO HealthNet share of the poison control costs by the percentage of managed care participants to total MO HealthNet participants; and

6. Effective July 1, 2006, the costs for including out-of-state Medicaid days is calculated by subtracting the hospital's per diem rate from its trended per diem cost and multiplying

this difference by the out-of-state Medicaid days as determined from the regression analysis performed using the out-of-state days from the fourth, fifth, and sixth prior year cost reports.

(C) For new hospitals that do not have a base cost report, Direct Medicaid Payments shall be estimated as follows:

1. Hospitals receiving Direct Medicaid Payments shall be divided into quartiles based on total beds;

2. Direct Medicaid Payments shall be individually summed by quartile and then divided by the total beds in the quartile to yield an average Direct Medicaid Payment per bed;

3. The number of beds for the new hospital without the base cost report shall be multiplied by the average Direct Medicaid Payment per bed to determine the hospital's estimated Direct Medicaid Payment for the current state fiscal year;

4. For a new hospital licensed after February 1, 2007, estimated total Direct Medicaid Payments for the current state fiscal year shall be divided by the estimated MO HealthNet patient days for the new hospital's quartile to obtain the estimated Direct Medicaid adjustment per patient day. This adjustment per day shall be added to the new hospital's MO HealthNet rate as determined in 13 CSR 70-15.010(4), so that the hospital's Direct Medicaid Payment per day is included in its per diem rate, rather than as a separate Add-On Payment. When the hospital's per diem rate is determined from its first full year cost report in accordance with 13 CSR 70-15.010(1)–(3), the facility's Direct Medicaid Payment will be calculated in accordance with subsection (2)(B) and reimbursed as an Add-On Payment rather than as part of the per diem rate. If the hospital is defined as a critical access hospital, its MO HealthNet per diem rate and Direct Medicaid Payment will be determined in accordance with 13 CSR 70-15.010(5)(F); and

5. A facility previously enrolled for participation in the MO HealthNet Program, which either voluntarily or involuntarily terminates its participation in the MO HealthNet Program and which reenters the MO HealthNet Program, shall have its Direct Medicaid Payments determined in accordance with 13 CSR 70-15.010(3)(B)2.]

#### (1) Outpatient Direct Medicaid Payments.

(A) Outpatient direct Medicaid payments will be made to hospitals for the following allowable MO HealthNet cost:

1. The increased MO HealthNet cost resulting from the Federal Reimbursement Allowance (FRA) assessment becoming an allowable cost on January 1, 1999.

(B) The MO HealthNet Division will calculate the outpatient direct Medicaid payment as follows:

1. The Medicaid share of the outpatient FRA assessment will be calculated by dividing the hospital's outpatient Medicaid charges by the total outpatient hospital charges from the base year cost report to arrive at the Medicaid utilization percentage. This percentage is then multiplied by the outpatient FRA assessment for the current state fiscal year (SFY) to arrive at the increase allowable Medicaid cost for the outpatient FRA assessment.

A. Effective for payments made on or after July 1, 2022, only the fee-for-service (FFS) component of the Medicaid share of the outpatient FRA assessment will be included in the outpatient direct Medicaid payment.

*AUTHORITY:* sections 208.153, 208.201, and 660.017, RSMo 2016, and section 208.152, RSMo Supp. 2021. This rule was previously filed as part of 13 CSR 70-15.010. Emergency rule filed April 30, 2020, effective May 15, 2020, expired Feb. 24, 2021. Original rule filed April 30, 2020, effective Nov. 30, 2020. Emergency amendment

filed Aug. 26, 2021, effective Sept. 10, 2021, expired March 8, 2022. Amended: Filed Aug. 26, 2021, effective March 30, 2022. Emergency amendment filed June 14, 2022, effective July 1, 2022, expires Feb. 23, 2023. Amended: Filed June 14, 2022.

**PUBLIC COST:** This proposed amendment is estimated to save state agencies approximately \$969.6 million (state share: \$325.4 million FRA and \$4.7 million IGT for DMH) for SFY 2023. This proposed amendment is estimated to cost political subdivisions approximately \$168.8 million for SFY 2023.

**PRIVATE COST:** This proposed amendment is estimated to cost in-state private entities approximately \$800.7 million for SFY 2023.

**NOTICE TO SUBMIT COMMENTS:** Anyone may file a statement in support of or in opposition to this proposed amendment with the Department of Social Services, Legal Services Division-Rulemaking, PO Box 1527, Jefferson City, MO 65102-1527, or by email to Rules.Comment@dss.mo.gov. To be considered, comments must be received within thirty (30) days after publication of this notice in the *Missouri Register*. No public hearing is scheduled.

**FISCAL NOTE  
PUBLIC COST**

- I. **Department Title:** 13 Social Services  
**Division Title:** 70 MO HealthNet Division  
**Chapter Title:** 15 Hospital Program

<b>Rule Number and Name:</b>	13 CSR 70-15.015 Direct Medicaid Payments
<b>Type of Rulemaking:</b>	Proposed Amendment

II. **SUMMARY OF FISCAL IMPACT**

Affected Agency or Political Subdivision	Estimated Cost of Compliance in the Aggregate
<b>Other Government (Public) &amp; State Hospitals enrolled in MO HealthNet - 38</b>	<b>Estimated cost for SFY 2023: \$168.8 million</b>
<b>Department of Social Services, MO HealthNet Division</b>	<b>Estimated savings for SFY 2023: Total \$969.6 million; State Share \$325.4 million (FRA) State Share \$4.7 million (IGT)</b>

III. **WORKSHEET**

<b>Other Government (Public) &amp; State Hospitals Cost:</b>			
<b>Estimated Cost for SFY 2023:</b>			
	FRA Fund	IGT Fund	Total
Estimated Cost to State Hospitals	\$62,009,634	\$13,889,104	\$75,898,738
Estimated Cost to Other Government (Public) Hospitals	\$92,940,355	\$0	\$92,940,355
Total Estimated Cost	\$154,949,989	\$13,889,104	\$168,839,093
State Share Percentage	34.0525%	34.0525%	34.0525%
Estimated State Share	\$52,764,345	\$4,729,587	\$57,493,932
<b>Department of Social Services, MO HealthNet Division Savings:</b>			
<b>Estimated Savings for SFY 2023:</b>			
	FRA Fund	IGT Fund	Total
Estimated Savings	\$955,673,724	\$13,889,104	\$969,562,828
State Share Percentage	34.0525%	34.0525%	34.0525%
Estimated State Share Savings	\$325,430,795	\$4,729,587	\$330,160,382

**IV. ASSUMPTIONS**

The following regulations are impacted by the change to the hospital reimbursement methodology and the impact of all the regulations should be netted to arrive at the total impact. The net impact is a cost to the state of \$7.6 million for SFY 2023.

13 CSR 70-15.010

13 CSR 70-15.015

13 CSR 70-15.220

13 CSR 70-15.230

The fiscal impact is estimated based on historical utilization and enrollment. Other variables such as the length of the Federal Public Health Emergency and Medicaid Expansion enrollment may indirectly affect the hospital utilization both positively and negatively. Due to the uncertainty of these variables, the state will continue to monitor the impacts to the Managed Care Organizations and hospitals.



**FISCAL NOTE  
PRIVATE COST**

- I. Department Title:** 13 Social Services  
**Division Title:** 70 MO HealthNet Division  
**Chapter Title:** 15 Hospital Program

<b>Rule Number and Title:</b>	13 CSR 70-15.015 Direct Medicaid Payments
<b>Type of Rulemaking:</b>	Proposed Amendment

**II. SUMMARY OF FISCAL IMPACT**

<b>Estimate of the number of entities by class which would likely be affected by the adoption of the rule:</b>	<b>Classification by types of the business entities which would likely be affected:</b>	<b>Estimate in the aggregate as to the cost of compliance with the rule by the affected entities:</b>
In-State Hospitals – 100	Private Hospitals enrolled in MO HealthNet	Estimated cost for SFY 2023: \$800.7 million

**III. WORKSHEET**

<b><u>In-State Private Hospitals Cost:</u></b>			
<b><u>Estimated Cost for SFY 2023:</u></b>			
	FRA Fund	IGT Fund	Total
Estimated Cost to In-State Private Hospitals	\$800,723,735	\$0	\$800,723,735
State Share Percentage	34.0525%	34.0525%	34.0525%
Estimated State Share	\$272,666,450	\$0	\$272,666,450

**IV. ASSUMPTIONS**

The following regulations are impacted by the change to the hospital reimbursement methodology and the impact of all the regulations should be netted to arrive at the total impact. The net impact is a cost to the state of \$7.6 million for SFY 2023.

13 CSR 70-15.010  
13 CSR 70-15.015  
13 CSR 70-15.220  
13 CSR 70-15.230

The fiscal impact is estimated based on historical utilization and enrollment. Other variables such as the length of the Federal Public Health Emergency and Medicaid Expansion enrollment may indirectly affect the hospital utilization both positively and negatively. Due to the uncertainty of these variables, the state will continue to monitor the impacts to the Managed Care Organizations and hospitals.

**Title 13—DEPARTMENT OF SOCIAL SERVICES**  
**Division 70—MO HealthNet Division**  
**Chapter 15—Hospital Program**

**PROPOSED AMENDMENT**

**13 CSR 70-15.110 Federal Reimbursement Allowance (FRA).** The division is amending subparagraph (1)(A)13.G., and adding new section (5).

*PURPOSE: This rule establishes the formula for determining the Federal Reimbursement Allowance each hospital, except public hospitals which are operated primarily for the care and treatment of mental disorders and any hospital operated by the Department of Health and Senior Services, is required to pay for the privilege of engaging in the business of providing inpatient health care in Missouri.*

(1) Federal Reimbursement Allowance (FRA). FRA shall be assessed as described in this section.

(A) Definitions.

1. Bad debts—Amounts considered to be uncollectible from accounts and notes receivable that were created or acquired in providing services. Allowable bad debts include the costs of caring for patients who have insurance, but their insurance does not cover the particular service procedures or treatment rendered.

2. Base cost report—Desk-reviewed Medicare/Medicaid cost report. The Medicare/Medicaid Cost Report version 2552-96 (CMS 2552-96) shall be used for fiscal years ending on or after September 30, 1996. The Medicare/Medicaid Cost Report version 2552-10 (CMS 2552-10) shall be used for fiscal years beginning on and after May 1, 2010. When a hospital has more than one (1) cost report with periods ending in the base year, the cost report covering a full twelve- (12-) month period will be used. If none of the cost reports covers a full twelve (12) months, the cost report with the latest period will be used. If a hospital's base cost report is less than or greater than a twelve- (12-) month period, the data shall be adjusted, based on the number of months reflected in the base cost report, to a twelve- (12-) month period.

3. Charity care—Those charges written off by a hospital based on the hospital's policy to provide health care services free of charge or at a reduced charge because of the indigence or medical indigence of the patient.

4. Contractual allowances—Difference between established rates for covered services and the amount paid by third-party payers under contractual agreements. The Federal Reimbursement Allowance (FRA) is a cost to the hospital, regardless of how the FRA is remitted to the MO HealthNet Division, and shall not be included in contractual allowances for determining revenues. Any redistributions of MO HealthNet payments by private entities acting at the request of participating health care providers shall not be included in contractual allowances or determining revenues or cost of patient care.

5. Department—Department of Social Services.

6. Director—Director of the Department of Social Services.

7. Division—MO HealthNet Division, Department of Social Services.

8. Engaging in the business of providing inpatient health care—Accepting payment for inpatient services rendered.

9. Federal Reimbursement Allowance (FRA)—The fee assessed to hospitals for the privilege of engaging in the business of providing inpatient health care in Missouri. The FRA is an allowable cost to the hospital.

10. Fiscal period—Twelve- (12-) month reporting period determined by each hospital.

11. Gross hospital service charges—Total charges made by the hospital for inpatient and outpatient hospital services that are covered under 13 CSR 70-15.010.

12. Hospital—A place devoted primarily to the maintenance and operation of facilities for the diagnosis, treatment, or care for not fewer than twenty-four (24) hours in any week of three (3) or more nonrelated individuals suffering from illness, disease, injury, deformity, or other abnormal physical conditions; or a place devoted primarily to provide, for not fewer than twenty-four (24) hours in any week, medical or nursing care for three (3) or more nonrelated individuals. The term hospital does not include convalescent, nursing, shelter, or boarding homes as defined in Chapter 198, RSMo.

13. Hospital revenues subject to FRA assessment effective July 1, 2008—Each hospital's inpatient adjusted net revenues and outpatient adjusted net revenues subject to the FRA assessment will be determined as follows:

A. Obtain "Gross Total Charges" from Worksheet G-2, Line 25, Column 3 from CMS 2552-96, or Worksheet G-2, Line 28, Column 3 from CMS 2552-10, of the third prior year cost report (i.e., FRA fiscal year cost report) for the hospital. Charges shall exclude revenues for physician services. Charges related to activities subject to the Missouri taxes assessed for outpatient retail pharmacies and nursing facility services shall also be excluded. "Gross Total Charges" will be reduced by the following:

(I) "Nursing Facility Charges" from Worksheet C, Part I, Line 35, Column 6 from CMS 2552-96, or Worksheet C, Part I, Line 45, Column 6 from CMS 2552-10;

(II) "Swing Bed Nursing Facility Charges" from Worksheet G-2, Line 5, Column 1 from CMS 2552-96, or Worksheet G-2, Line 6, Column 1 from CMS 2552-10;

(III) "Nursing Facility Ancillary Charges" as determined from the Department of Social Services, MO HealthNet Division, nursing home cost report. (Note: To the extent that the gross hospital charges, as specified in subparagraph (1)(A)13.A. above, include long-term care charges, the charges to be excluded through this step shall include all long-term care ancillary charges including skilled nursing facility, nursing facility, and other long-term care providers based at the hospital that are subject to the state's provider tax on nursing facility services.);

(IV) "Distinct Part Ambulatory Surgical Center Charges" from Worksheet G-2, Line 22, Column 2 from CMS 2552-96, or Worksheet G-2, Line 25, Column 2 from CMS 2552-10;

(V) "Ambulance Charges" from Worksheet C, Part I, Line 65, Column 7 from CMS 2552-96, or Worksheet C, Part I, Line 95, Column 7 from CMS 2552-10;

(VI) "Home Health Charges" from Worksheet G-2, Line 19, Column 2 from CMS 2552-96, or Worksheet G-2, Line 22, Column 2 from CMS 2552-10;

(VII) "Total Rural Health Clinic Charges" from Worksheet C, Part I, Column 7, Lines 63.50–63.59 from CMS 2552-96, or Worksheet C, Part I, Column 7, Line 88 and subsets from CMS 2552-10; and

(VIII) "Other Non-Hospital Component Charges" from Worksheet G-2, Lines 6, 8, 21, 21.02, 23, and 24 from CMS 2552-96, or Worksheet G-2, Lines 5, 7, 9, 21, 24, 26, and 27 from CMS 2552-10;

B. Obtain "Net Revenue" from Worksheet G-3, Line 3, Column 1. The state will ensure this amount is net of bad debts and other uncollectible charges by survey methodology;

C. "Adjusted Gross Total Charges" (the result of the computations in subparagraph (1)(A)13.A.) will then be further adjusted by a hospital-specific collection-to-charge ratio determined as follows:

(I) Divide "Net Revenue" by "Gross Total Charges"; and

(II) "Adjusted Gross Total Charges" will be multiplied by the result of part (1)(A)13.C.(I) to yield "Adjusted Net Revenue";

D. Obtain "Gross Inpatient Charges" from Worksheet G-2, Line 25, Column 1 from CMS 2552-96, or Worksheet G-2, Line 28, Column 1 from CMS 2552-10, of the most recent cost report that is available for a hospital;

E. Obtain "Gross Outpatient Charges" from Worksheet G-2, Line 25, Column 2 from CMS 2552-96, or Worksheet G-2, Line 28,

Column 2 from CMS 2552-10, of the most recent cost report that is available for a hospital;

F. Total “Adjusted Net Revenue” will be allocated between “Net Inpatient Revenue” and “Net Outpatient Revenue” as follows:

(I) “Gross Inpatient Charges” will be divided by “Gross Total Charges”;

(II) “Adjusted Net Revenue” will then be multiplied by the result to yield “Net Inpatient Revenue”; and

(III) The remainder will be allocated to “Net Outpatient Revenue”; and

G. The trend indices, if greater than 0%, will be determined based on the Health Care Costs index as published in *Healthcare Cost Review* by Institute of Health Systems (IHS), or equivalent publication, regardless of any changes in the name of the publication or publisher, for each State Fiscal Year (SFY). The trend indices listed below will be applied to the apportioned inpatient adjusted net revenue and outpatient adjusted net revenue in order to inflate or trend forward the adjusted net revenues from the FRA fiscal year cost report to the current state fiscal year to determine the inpatient and outpatient adjusted net revenues subject to the FRA assessment.

(I) SFY 2020 =

(a) Inpatient Adjusted Net Revenues—0%

(b) Outpatient Adjusted Net Revenues—2.9%

(II) SFY 2021 =

(a) Inpatient Adjusted Net Revenues—3.2%

(b) Outpatient Adjusted Net Revenues—0%

(III) SFY 2022 =

(a) Inpatient Adjusted Net Revenues—4.2%

(b) Outpatient Adjusted Net Revenues—0%

(IV) SFY 2023 =

(a) Inpatient Adjusted Net Revenues—3.8%

(b) Outpatient Adjusted Net Revenues—0%

**(5) Beginning July 1, 2022, the FRA assessment shall be determined at a rate of five and four tenths percent (5.40%) of each hospital’s inpatient adjusted net revenues and outpatient adjusted net revenues as set forth in paragraph (1)(A)13. The FRA assessment rate will be applied individually to the hospital’s inpatient adjusted net revenues and outpatient adjusted net revenues. The hospital’s total FRA assessment is the sum of the assessment determined from its inpatient adjusted net revenue plus the assessment determined for its outpatient adjusted net revenue.**

*AUTHORITY: sections 208.201, 208.453, 208.455, and 660.017, RSMo 2016. Emergency rule filed Sept. 21, 1992, effective Oct. 1, 1992, expired Jan. 28, 1993. Emergency rule filed Jan. 15, 1993, effective Jan. 25, 1993, expired May 24, 1993. Original rule filed Sept. 21, 1992, effective June 7, 1993. For intervening history, please consult the **Code of State Regulations**. Emergency amendment filed June 15, 2022, effective July 1, 2022, expires Feb. 23, 2023. Amended: Filed June 15, 2022.*

*PUBLIC COST: For SFY 2023, this proposed amendment will result in FRA Assessment cost to state agencies or political subdivisions approximately \$3.4 million for SFY 2023.*

*PRIVATE COST: For SFY 2023, this proposed amendment will result in FRA Assessment cost to private entities of approximately \$20.1 million for SFY 2023.*

*NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Department of Social Services, Legal Services Division-Rulemaking, PO Box 1527, Jefferson City, MO 65102-1527, or by email to Rules.Comment@dss.mo.gov. To be considered, comments must be received within thirty (30) days after publication of this notice in the **Missouri Register**. No public hearing is scheduled.*

**FISCAL NOTE  
PUBLIC COST**

- I. Department Title:** Title 13 - Department of Social Services  
**Division Title:** Division 70 - MO HealthNet Division  
**Chapter Title:** Chapter 15 – Hospital Program

<b>Rule Number and Title:</b>	13 CSR 70-15.110 Federal Reimbursement Allowance (FRA)
<b>Type of Rulemaking:</b>	Proposed Amendment

**II. SUMMARY OF FISCAL IMPACT**

<b>Affected Agency or Political Subdivision</b>	<b>Estimated Cost of Compliance in the Aggregate</b>
<b>Other Government (Public) &amp; State Hospitals - 38</b>	<b>Estimated cost for: SFY 2023 - \$3.4 million</b>

**III. WORKSHEET****Estimated Assessment at 5.40% for SFY 2023:**

	No. of Facilities	Inpatient Revenues	Outpatient Revenues	Total
Public Facilities Revenues	38	\$1,668,002,896	\$1,868,974,452	\$3,536,977,348
FRA Assessment Rate		5.40%	5.40%	5.40%
Total Assessment without Trend		\$90,072,156	\$100,924,620	\$190,996,777
Revenue Trend for SFY 2022		3.80%	0.00%	
Total Revenues Trended		\$1,731,387,006	\$1,868,974,452	\$3,600,361,458
FRA Assessment Rate		5.40%	5.40%	5.40%
Total Assessment with Trend		\$93,494,898	\$100,924,620	\$194,419,519
Impact of Trend (Assessment with trend less Assessment without trend)				\$3,422,742

#### **IV. ASSUMPTIONS**

This fiscal note reflects the total FRA Assessment of 5.40% for July 1, 2022 through June 30, 2023. The fiscal note is based on establishing the FRA Assessment rate as noted above and a trend of 3.8% on inpatient revenues and 0% on outpatient revenues beginning July 1, 2022. The FRA Assessment rate is levied upon Missouri hospitals' trended inpatient and outpatient net adjusted revenues in accordance with the Missouri Partnership Plan.

**FISCAL NOTE  
PRIVATE COST**

- I. Department Title:** Title 13 - Department of Social Services  
**Division Title:** Division 70 - MO HealthNet Division  
**Chapter Title:** Chapter 15 – Hospital Program

<b>Rule Number and Title:</b>	13 CSR 70-15.110 Federal Reimbursement Allowance (FRA)
<b>Type of Rulemaking:</b>	Proposed Amendment

**II. SUMMARY OF FISCAL IMPACT**

Estimate of the number of entities by class which would likely be affected by the adoption of the proposed rule:	Classification by types of the business entities which would likely be affected:	Estimate in the aggregate as to the cost of compliance with the rule by the affected entities:
100	Hospitals	Estimated cost for: SFY 2023 - \$20.1 million

**III. WORKSHEET****Estimated Assessment at 5.40% for SFY 2023:**

	No. of Facilities	Inpatient Revenues	Outpatient Revenues	Total
Private Facilities Revenues	100	\$9,783,611,519	\$9,765,148,338	\$19,548,759,857
FRA Assessment Rate		5.40%	5.40%	5.40%
Total Assessment without Trend		\$528,315,022	\$527,318,010	\$1,055,633,032
Revenue Trend for SFY 2023		3.80%	0.00%	
Total Revenues Trended		\$10,155,388,757	\$9,765,148,338	\$19,920,537,095
FRA Assessment Rate		5.40%	5.40%	5.40%
Total Assessment with Trend		\$548,390,993	\$527,318,010	\$1,075,709,003
Impact of Trend (Assessment with trend less Assessment without trend)				\$20,075,971

#### **IV. ASSUMPTIONS**

This fiscal note reflects the total FRA Assessment of 5.40% for July 1, 2022 through June 30, 2023. The fiscal note is based on establishing the FRA Assessment rate as noted above and a trend of 3.8% on inpatient revenues and 0% on outpatient revenues beginning July 1, 2022. The FRA Assessment rate is levied upon Missouri hospitals' trended inpatient and outpatient net adjusted revenues in accordance with the Missouri Partnership Plan.

**Title 13—DEPARTMENT OF SOCIAL SERVICES**  
**Division 70—MO HealthNet Division**  
**Chapter 15—Hospital Program**

**PROPOSED AMENDMENT**

**13 CSR 70-15.160 Outpatient Hospital Services Reimbursement Methodology.** The division is amending section (5).

*PURPOSE: This proposed amendment updates all documents incorporated by reference and used to create the outpatient simplified fee schedule.*

**(5) Outpatient Simplified Fee Schedule (OSFS) Payment Methodology.**

(A) Definitions. The following definitions will be used in administering section (5) of this rule:

1. Ambulatory Payment Classification (APC). Medicare's ambulatory payment classification assignment groups of Current Procedural Terminology (CPT) or Healthcare Common Procedures Coding System (HCPCS) codes. APCs classify and group clinically similar outpatient hospital services that can be expected to consume similar amounts of hospital resources. All services within an APC group have the same relative weight used to calculate the payment rates;

2. APC conversion factor. The unadjusted national conversion factor calculated by Medicare effective January 1 of each year, as published with the Medicare Outpatient Prospective Payment System (OPPS) Final Rule, and used to convert the APC relative weights into a dollar payment. The Medicare OPPS Final Rule is incorporated by reference and made a part of this rule as published by the *[Department of Social Services, MO HealthNet Division, 615 Howerton Court, Jefferson City, MO 65109, at its website at <https://dssruletracker.mo.gov/dss-proposed-rules/welcome.action>, December 9, 2020] Centers for Medicare & Medicaid Services, 7500 Security Boulevard, Baltimore, MD 21244, and available at <https://www.govinfo.gov/content/pkg/FR-2021-11-16/pdf/2021-24011.pdf>, November 19, 2021. This rule does not incorporate any subsequent amendments or additions;*

3. APC relative weight. The national relative weights calculated by Medicare for the Outpatient Prospective Payment System;

4. Current Procedural Terminology (CPT). A medical code set that is used to report medical, surgical, and diagnostic procedures and services to entities such as physicians, health insurance companies, and accreditation organizations;

5. Dental procedure codes. The procedure codes found in the Code on Dental Procedures and Nomenclature (CDT), a national uniform coding method for dental procedures maintained by the American Dental Association;

6. Federally-Deemed Critical Access Hospital. Hospitals that meet the federal definition found in section 1820(c)(2)(B) of the Social Security Act;

7. HCPCS. The national uniform coding method maintained by the Centers for Medicare *[and]* & Medicaid Services (CMS) that incorporates the American Medical Association (AMA) Physicians CPT and the three (3) HCPCS unique coding levels, I, II, and III;

8. Medicare Inpatient Prospective Payment System (IPPS) wage index. The wage area index values are calculated annually by Medicare, published as part of the Medicare IPPS Final Rule;

9. Missouri conversion factor. The single, statewide conversion factor used by the MO HealthNet Division (MHD) to determine the APC-based fees, uses a formula based on Medicare OPPS. The formula consists of: sixty percent (60%) of the APC conversion factor, as defined in paragraph (5)(A)2. multiplied by the St. Louis, MO Medicare IPPS wage index value, plus the remaining forty percent (40%) of the APC conversion factor, with no wage index adjustment;

10. Nominal charge provider. A nominal charge provider is determined from the *[fourth]* **third** prior year audited Medicaid cost

report. The hospital must meet the following criteria:

A. A public non-state governmental acute care hospital with a low-income utilization rate (LIUR) of at least *[fifty percent (50%)]* **forty percent (40%)** and a Medicaid inpatient utilization rate (MIUR) greater than one (1) standard deviation from the mean, and is licensed for fifty (50) inpatient beds or more and has an occupancy rate of at least forty percent (40%). The hospital must meet one (1) of the federally mandated Disproportionate Share qualifications; or

B. The hospital is a public hospital operated by the Department of Mental Health primarily for the care and treatment of mental disorders; and

C. A hospital physically located in the State of Missouri;

11. Outpatient Prospective Payment System (OPPS). Medicare's hospital outpatient prospective payment system mandated by the Balanced Budget Refinement Act of 1999 (BBRA) and the Medicare, Medicaid, and State Children's Health Insurance Program (SCHIP) Benefits Improvement and Protection Act (BIPA) of 2000; and

12. Payment level adjustment. The percentage applied to the Medicare fee to derive the OSFS fee.

(B) Effective for dates of service beginning July 20, 2021, outpatient hospital services shall be reimbursed on a predetermined fee-for-service basis using an OSFS based on the APC groups and fees under the Medicare Hospital OPPS. When service coverage and payment policy differences exist between Medicare OPPS and Medicaid, MHD policies and fee schedules are used. The fee schedule will be updated as follows:

1. MHD will review and adjust the OSFS annually on July 1 based on the payment method described in subsection (5)(D); and

2. The OSFS is incorporated by reference and made a part of this rule as published by the Department of Social Services, MO HealthNet Division, 615 Howerton Court, Jefferson City, MO 65109, at its website at *[<https://dssruletracker.mo.gov/dss-proposed-rules/welcome.action>, July 20, 2021]* **<https://dss.mo.gov/mhd/providers/fee-for-service-providers.htm>, June 15, 2022.** This rule does not incorporate any subsequent amendments or additions.

(D) Fee schedule methodology. Fees for outpatient hospital services covered by the MO HealthNet program are determined by the HCPCS procedure code at the line level and the following hierarchy:

1. The APC relative weight or payment rate assigned to the procedure in the Medicare OPPS *Addendum B* is used to calculate the fee for the service, with the exception of the hospital observation per hour fee which is calculated based on the method described in subparagraph (5)(D)1.B. Fees derived from APC weights and payment rates are established using the Medicare OPPS *Addendum B* effective as of January 1 of each year as published by the CMS for Medicare OPPS. The Medicare OPPS *Addendum B* is incorporated by reference and made a part of this rule as published by the *[Department of Social Services, MO HealthNet Division, 615 Howerton Court, Jefferson City, MO 65109, at its website at <https://dssruletracker.mo.gov/dss-proposed-rules/welcome.action>, December 29, 2020] Centers for Medicare & Medicaid Services, 7500 Security Boulevard, Baltimore, MD 21244, and available at <https://www.cms.gov/medicare/medicare-fee-service-payment/hospitaloutpatientppsaddendum-and-addendum-b-updates/january-2022-0>, January 18, 2022.* This rule does not incorporate any subsequent amendments or additions.

A. The fee is calculated using the APC relative weight times the Missouri conversion factor. The resulting amount is then multiplied by the payment level adjustment of ninety percent (90%) to derive the OSFS fee.

B. The hourly fee for observation is calculated based on the relative weight for the Medicare APC (using the Medicare OPPS *Addendum A* effective as of January 1 of each year as published by the CMS for Medicare OPPS), which corresponds with comprehensive



observation services multiplied by the Missouri conversion factor divided by forty (40), the maximum payable hours by Medicare. The resulting amount is then multiplied by the payment level adjustment of ninety percent (90%) to derive the OSFS fee. The Medicare OPPS Addendum A is incorporated by reference and made a part of this rule as published by the Centers for Medicare [and] & Medicaid Services, 7500 Security Boulevard, Baltimore, MD 21244, and available at [<https://dssruletracker.mo.gov/dss-proposed-rules/welcome.action>, July 6, 2021] <https://www.cms.gov/medicare/medicare-fee-service-payment/hospitaloutpatientppsaddendum-and-addendum-b-updates/january-2022>, January 18, 2022. This rule does not incorporate any subsequent amendments or additions.

C. For those APCs with no assigned relative weight, ninety percent (90%) of the Medicare APC payment rate is used as the fee;

2. If there is no APC relative weight or APC payment rate established for a particular service in the Medicare OPPS Addendum B, then the MHD approved fee will be ninety percent (90%) of the rate listed on other Medicare fee schedules, effective as of January 1 of each year: Clinical Laboratory Fee Schedule; Physician Fee Schedule; and Durable Medical Equipment Prosthetics/Orthotics and Supplies Fee Schedule, applicable to the outpatient hospital service.

A. The Medicare *Clinical Laboratory Fee Schedule* is incorporated by reference and made a part of this rule as published by the Centers for Medicare [and] & Medicaid Services, 7500 Security Boulevard, Baltimore, MD 21244, and available at [<https://www.cms.gov/license/ama?file=/files/zip/21clabq1.zip>, January 5, 2021] <https://www.cms.gov/medicare/medicare-fee-service-payment/clinicallabfeeschedclinical-laboratory-fee-schedule-files/22clabq1>, December 29, 2021. This rule does not incorporate any subsequent amendments or additions.

B. The Medicare *Physician Fee Schedule* is incorporated by reference and made a part of this rule as published by the Centers for Medicare [and] & Medicaid Services, 7500 Security Boulevard, Baltimore, MD 21244, and available at [<https://www.cms.gov/medicare/medicare-fee-service-payment/physicianfeeschedpfs-carrier-specific-files/all-states-0> January 4, 2021,] <https://www.cms.gov/medicare/medicare-fee-service-payment/physicianfeeschedpfs-carrier-specific-files/all-states-1>, December 18, 2021. This rule does not incorporate any subsequent amendments or additions.

C. The Medicare *Durable Medical Equipment Prosthetics/Orthotics and Supplies Fee Schedule* is incorporated by reference and made a part of this rule as published by the Centers for Medicare [and] & Medicaid Services, 7500 Security Boulevard, Baltimore, MD 21244, and available at [<https://www.cms.gov/medicare/medicare-fee-service-payment/dmeposfeescheddmepos-fee-schedule/dme21>, December 2, 2020] <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/DMEPOSFeeSched/DMEPOS-Fee-Schedule>, December 15, 2021. This rule does not incorporate any subsequent amendments or additions;

3. Fees for dental procedure codes in the outpatient hospital setting are calculated based on thirty-eight and one half percent (38.5%) of the fiftieth percentile fee for Missouri reflected in the [2021] 2022 *National Dental Advisory Service* (NDAS). The [2021] 2022 NDAS is incorporated by reference and made a part of this rule as published by Wasserman Medical & Dental at its website at <https://wasserman-medical.com/product-category/dental/ndas/>, and available at the MO HealthNet Division, 615 Howerton Court, Jefferson, City MO 65109, [April 20, 2021] January 31, 2022. This rule does not incorporate any subsequent amendments or additions;

4. If there is no APC relative weight, APC payment rate, other Medicare fee schedule rate, or NDAS rate established for a covered outpatient hospital service, then a MO HealthNet fee will be determined using the MHD *Dental*, *Medical*, *Other Medical* or *Independent Lab—Technical Component* fee schedules.

A. The MHD *Dental Fee Schedule* is incorporated by reference and made a part of this rule as published by the Department of Social Services, MO HealthNet Division, 615 Howerton Court, Jefferson City, MO 65109, [at its website at <https://dss.mo.gov/mhd/providers/pages/cptagree.htm>, April 12, 2021] and available at <https://dss.mo.gov/mhd/providers/pages/cptagree.htm>, June 7, 2022. This rule does not incorporate any subsequent amendments or additions.

B. The MHD *Medical Fee Schedule* is incorporated by reference and made a part of this rule as published by the Department of Social Services, MO HealthNet Division, 615 Howerton Court, Jefferson City, MO 65109, [at its website at <https://dssruletracker.mo.gov/dss-proposed-rules/welcome.action>, July 13, 2021] and available at <https://dss.mo.gov/mhd/providers/pages/cptagree.htm>, June 7, 2022. This rule does not incorporate any subsequent amendments or additions.

C. The MHD *Other Medical Fee Schedule* is incorporated by reference and made a part of this rule as published by the Department of Social Services, MO HealthNet Division, 615 Howerton Court, Jefferson City, MO 65109, [at its website at <https://dss.mo.gov/mhd/providers/pages/cptagree.htm>, April 12, 2021] and available at <https://dss.mo.gov/mhd/providers/pages/cptagree.htm>, June 7, 2022. This rule does not incorporate any subsequent amendments or additions.

D. The MHD *Independent Lab—Technical Component Fee Schedule* is incorporated by reference and made a part of this rule as published by the Department of Social Services, MO HealthNet Division, 615 Howerton Court, Jefferson City, MO 65109, [at its website at <https://dss.mo.gov/mhd/providers/pages/cptagree.htm>, April 12, 2021] and available at <https://dss.mo.gov/mhd/providers/pages/cptagree.htm>, June 7, 2022. This rule does not incorporate any subsequent amendments or additions;

5. In-state federally-deemed critical access hospitals will receive an additional forty percent (40%) of the rate as determined in paragraph (5)(B)2. for each billed procedure code; and

6. Nominal charge providers will receive an additional twenty-five percent (25%) of the rate as determined in paragraph (5)(B)2. for each billed procedure code.

(E) Packaged services. MHD adopts Medicare guidelines for procedure codes identified as “Items and Services Packaged into APC Rates” under Medicare OPPS Addendum D1. These procedures are designated as always packaged. Claim lines with packaged procedure codes will be considered paid but with a payment of zero (0). The Medicare OPPS Addendum D1 is incorporated by reference and made a part of this rule as published by the Centers for Medicare [and] & Medicaid Services, 7500 Security Boulevard, Baltimore, MD 21244, and available at [[https://www.cms.gov/medicare/medicare-fee-for-service-payment/hospitaloutpatientpps/downloads/cms1392fc\\_addendum\\_d1.pdf](https://www.cms.gov/medicare/medicare-fee-for-service-payment/hospitaloutpatientpps/downloads/cms1392fc_addendum_d1.pdf), December 29, 2020] <https://www.cms.gov/license/ama?file=/files/zip/2022-nfrm-ops-addenda.zip>, November 3, 2021. This rule does not incorporate any subsequent amendments or additions.

*AUTHORITY:* sections 208.153, 208.201, and 660.017, RSMo 2016, and section 208.152, RSMo Supp. 2021. Emergency rule filed June 20, 2002, effective July 1, 2002, expired Feb. 27, 2003. Original rule filed June 14, 2002, effective Jan. 30, 2003. For intervening history, please consult the *Code of State Regulations*. Emergency amendment filed June 13, 2022, effective July 1, 2022, expires Feb. 23, 2023. Amended: Filed June 13, 2022.

*PUBLIC COST:* This proposed amendment is estimated to cost the Department of Social Services \$11,236,577.00 in SFY 2023. This

*proposed amendment will not cost state agencies or political subdivisions, other than the Department of Social Services, more than five hundred dollars (\$500) for SFY 2023.*

*PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars (\$500) for SFY 2023.*

**NOTICE TO SUBMIT COMMENTS:** *Anyone may file a statement in support of or in opposition to this proposed amendment with the Department of Social Services, Legal Services Division-Rulemaking, PO Box 1527, Jefferson City, MO 65102-1527, or by email to [Rules.Comment@dss.mo.gov](mailto:Rules.Comment@dss.mo.gov). To be considered, comments must be received within thirty (30) days after publication of this notice in the **Missouri Register**. A public hearing will not be scheduled.*

**FISCAL NOTE  
PUBLIC COST**

- I. Department Title:** Title 13 - Department of Social Services  
**Division Title:** Division 70 - MO HealthNet Division  
**Chapter Title:** Chapter 15 – Hospital Program

<b>Rule Number and Title:</b>	13 CSR 70-15.160 Outpatient Hospital Services Reimbursement Methodology
<b>Type of Rulemaking:</b>	Proposed Amendment

**II. SUMMARY OF FISCAL IMPACT**

Affected Agency or Political Subdivision	Estimated Cost of Compliance in the Aggregate
<b>Other Government (Public) &amp; State Hospitals enrolled in MO HealthNet - 32</b>	<b>No Fiscal Impact</b>
<b>Department of Social Services, MO HealthNet Division</b>	<b>SFY 2023 Impact:</b> <b>Total Costs is estimated at \$11.2 million;</b> <b>State Share is estimated at \$3.8 million</b>

**III. WORKSHEET**

<b><u>Department of Social Services, MO HealthNet Division Savings:</u></b>	
<b><u>Estimated Costs for 6 Months of SFY 2023:</u></b>	
Estimated Costs	\$11,236,577
Times FFY 2022 State Share Percentage	33.64%
Estimated State Share Savings	\$3,779,985

The state estimates that there is not a cost to other government (public) and state hospitals. The state anticipates an increase in payments in aggregate of \$3.5 million.

**IV. ASSUMPTIONS**

The estimated cost is due to Medicare increasing their rates for the following high volume services: emergency department visits, clinic visits, and some laboratory services.

**Title 13—DEPARTMENT OF SOCIAL SERVICES**  
**Division 70—MO HealthNet Division**  
**Chapter 15—Hospital Program**

**PROPOSED AMENDMENT**

**13 CSR 70-15.230 [Supplemental] Upper Payment Limit (UPL) Payment Methodology.** The division is amending section (2).

*PURPOSE:* This proposed amendment establishes a methodology for determining Upper Payment Limit (UPL) payments provided to state government-owned hospitals beginning July 1, 2022.

*[(2) Beginning with State Fiscal Year 2012, each participating hospital may be paid supplemental payments up to the Medicare Upper Payment Limit (UPL).]*

*(A) UPL Payment. Supplemental payments may be paid to qualifying hospitals for inpatient services. The total amount of supplemental payments made under this section in each year shall not exceed the Medicare Upper Payment Limit, after accounting for all other supplemental payments. Payments under this section will be determined prior to the determination of payments under subsection (2)(B) below authorizing Medicaid UPL Supplemental Payments for Low Income and Needy Care Collaboration hospitals.*

*1. The state shall determine the amount of Medicaid supplemental payments payable under this section on an annual basis. The state shall calculate the Medicare Upper Payment Limit for each of the three (3) categories of hospitals: state hospitals, non-state governmental hospitals, and private hospitals. The state shall apportion the Medicaid supplemental payments payable under this section to each of the three (3) categories of hospitals based on the proportionate Medicare Upper Payment Limits for each category of hospitals.*

*2. Each participating hospital may be paid its proportionate share of the UPL gap based upon its Medicaid inpatient utilization.*

*(B) Supplemental Payments for Low Income and Needy Care Collaboration Hospitals. Additional Supplemental Payments for Low Income and Needy Care Collaboration Hospitals may be made if there is room remaining under the UPL to make additional payments without exceeding the UPL, after making the UPL payments in subsection (2)(A) above.*

*1. Effective for dates of services on or after July 1, 2011, supplemental payments may be issued to qualifying hospitals for inpatient services after July 1, 2011. Maximum aggregate payments to all qualifying hospitals under this section shall not exceed the available Medicare Upper Payment Limit, less all other Medicaid inpatient payments to private hospitals under this State Plan which are subject to the Medicaid Upper Payment Limit.*

*2. Qualifying criteria. In order to qualify for the supplemental payment under this section, the private hospital must be affiliated with a state or local governmental entity through a Low Income and Needy Care Collaboration Agreement. The state or local governmental entity includes governmentally-supported hospitals.*

*A. A private hospital is defined as a hospital that is owned or operated by a private entity.*

*B. A Low Income and Needy Care Collaboration Agreement is defined as an agreement between a private hospital and a state or local governmental entity to collaborate for purposes of providing healthcare services to low income and needy patients.*

*C. Reimbursement methodology. Each qualifying private hospital may be eligible to receive supplemental payments. The total supplemental payments in any fiscal year*

*will not exceed the lesser of—*

*(I) The difference between each qualifying hospital's inpatient Medicaid billed charges and Medicaid payment the hospital receives for covered inpatient services for Medicaid participants during the fiscal year; or*

*(II) For hospitals participating in the Medicaid Disproportionate Share Hospital (DSH) program, the difference between the hospital's specific DSH cap and the hospital's DSH payments during the fiscal year.*

*D. Payments under this section will be determined after the determination of payments under subsection (2)(A) above authorizing Medicaid UPL supplemental payments.]*

**(2) Beginning with SFY 2023, state government-owned hospitals will be paid a semi-monthly payment up to the inpatient (IP) UPL gap.**

**(A) Prior to each SFY, the division shall calculate the estimated Medicaid payments for the coming SFY for each hospital. The total estimated Medicaid payments for each hospital shall be subtracted from the hospital's IP UPL calculated in accordance to the methodology set forth below then summed to calculate the IP UPL gap. The IP UPL gap is reduced by the estimated inpatient fee-for-service Graduate Medical Education (GME) payments for the coming SFY for each hospital to calculate the total amount of funding available. The available IP UPL gap is distributed to each hospital based on the hospital's percent of estimated Medicaid payments for the coming SFY to total estimated payments for the coming SFY for all state government-owned hospitals. The available gap under the IP UPL for each eligible hospital will be aggregated to create the supplemental payment amount. The total calculated supplemental payment amount will be paid to eligible hospitals.**

**1. The IP UPL will be determined based on the hospital's Medicaid inpatient costs using Medicare cost reporting principles. All Medicare cost report worksheet, column, or line references are based upon the Medicare Cost Report (MCR) CMS 2552-10 and should be adjusted for any CMS-approved successor MCR. The amount that Medicare would pay shall be calculated as follows:**

**A. Using Medicare cost report data within the previous two (2) years of the IP UPL demonstration dates in accordance with IP UPL guidelines set by CMS, Total Medicare Costs shall be derived from the reported Inpatient Hospital Cost on the following cost report variable locations:**

**(I) Worksheet D-1, Hospital/IPF/IRF Components, Column 1, Line 49;**

**(II) Plus Organ Acquisitions Cost from all applicable Worksheets D-4, Column 1, Line 69;**

**(III) Plus GME Aggregated Approved Amount from Worksheet E-4, Column 1, Line 49;**

**B. Total Medicare Patient Days shall be derived from Worksheet S-3, Part I, Column 6, Lines 14, 16, and 17 of the same cost report as the Total Medicare Costs;**

**C. A calculated Medicare Cost *Per Diem* shall be calculated by dividing the Total Medicare Costs by the hospital's Total Medicare Patient Days;**

**D. The calculated Medicare Cost *Per Diem* shall be multiplied by the total Medicaid Patient Days from a twelve- (12-) month data set from the prior two (2) years of the IP UPL demonstration dates in accordance with the IP UPL guidelines set by CMS to derive the hospital's IP UPL.**

**(I) The data source for the Medicaid Patient Days and Total Medicaid Payments shall be from the state's MMIS claims data;**

**E. The calculated IP UPL shall be inflated from the midpoint of the hospital's cost report period to the midpoint of the IP UPL demonstration period using the CMS PPS hospital market basket index; and**

**F. If payments in this section would result in payments to any category of hospitals in excess of the IP UPL calculation required by 42 CFR 447.272, payments for each eligible hospital receiving payments under this section will be reduced proportionately to ensure compliance with the IP UPL.**

*AUTHORITY: sections [208.152,] 208.153, [and] 208.201, and 660.017, RSMo 2016, and section 208.152, RSMo Supp. [2010] 2021. Emergency rule filed May 20, 2011, effective July 1, 2011, expired Dec. 28, 2011. Original rule filed May 20, 2011, effective Jan. 30, 2012. Emergency amendment filed June 14, 2022, effective July 1, 2022, expires Feb. 23, 2023. Amended: Filed June 14, 2022.*

*PUBLIC COST: This proposed amendment is estimated to cost state agencies approximately \$24.9 million (state share: \$7.4 million FRA and \$1.1 million IGT for DMH) for SFY 2023. This proposed amendment is estimated to increase payments to political subdivisions by approximately \$24.9 million for SFY 2023.*

*PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars (\$500) in the aggregate.*

*NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Department of Social Services, Legal Services Division-Rulemaking, PO Box 1527, Jefferson City, MO 65102-1527, or by email to Rules.Comment@dss.mo.gov. To be considered, comments must be received within thirty (30) days after publication of this notice in the **Missouri Register**. A public hearing will not be scheduled.*

**FISCAL NOTE  
PUBLIC COST**

- I. **Department Title:** 13 Social Services  
**Division Title:** 70 MO HealthNet Division  
**Chapter Title:** 15 Hospital Program

<b>Rule Number and Name:</b>	13 CSR 70-15.230 Upper Payment Limit (UPL) Payment Methodology
<b>Type of Rulemaking:</b>	Proposed Amendment

**II. SUMMARY OF FISCAL IMPACT**

Affected Agency or Political Subdivision	Estimated Cost of Compliance in the Aggregate
State Hospitals enrolled in MO HealthNet - 6	Estimated impact for SFY 2023: \$24.9 million
Department of Social Services, MO HealthNet Division	Estimated cost for SFY 2023: Total \$24.9 million; State Share \$7.4 million (FRA) State Share \$1.1 million (IGT)

**III. WORKSHEET**

<b>Other Government (Public) &amp; State Hospitals Impact:</b>			
<b>Estimated Cost for SFY 2023:</b>			
	FRA Fund	IGT Fund	Total
Estimated Impact to State Hospitals	\$21,577,960	\$3,323,160	\$24,901,120
Estimated Impact to Other Government (Public) Hospitals	\$0	\$0	\$0
Total Estimated Impact	\$21,577,960	\$3,323,160	\$24,901,120
State Share Percentage	34.0525%	34.0525%	34.0525%
Estimated State Share	\$7,347,835	\$1,131,619	\$8,479,454
<b>Department of Social Services, MO HealthNet Division Cost:</b>			
<b>Estimated Cost for 6 Months of SFY 2023:</b>			
	FRA Fund	IGT Fund	Total
Estimated Cost	\$21,577,960	\$3,323,160	\$24,901,120
State Share Percentage	34.0525%	34.0525%	34.0525%
Estimated State Share Cost	\$7,347,835	\$1,131,619	\$8,479,454

#### **IV. ASSUMPTIONS**

The following regulations are impacted by the change to the hospital reimbursement methodology and the impact of all the regulations should be netted to arrive at the total impact. The net impact is a cost to the state of \$7.6 million for SFY 2023.

13 CSR 70-15.010

13 CSR 70-15.015

13 CSR 70-15.220

13 CSR 70-15.230

The fiscal impact is estimated based on historical utilization and enrollment. Other variables such as the length of the Federal Public Health Emergency and Medicaid Expansion enrollment may indirectly affect the hospital utilization both positively and negatively. Due to the uncertainty of these variables, the state will continue to monitor the impacts to the Managed Care Organizations and hospitals.

**T**his section will contain the final text of the rules proposed by agencies. The order of rulemaking is required to contain a citation to the legal authority upon which the order or rulemaking is based; reference to the date and page or pages where the notice of proposed rulemaking was published in the *Missouri Register*; an explanation of any change between the text of the rule as contained in the notice of proposed rulemaking and the text of the rule as finally adopted, together with the reason for any such change; and the full text of any section or subsection of the rule as adopted which has been changed from that contained in the notice of proposed rulemaking. The effective date of the rule shall be not less than thirty (30) days after the date of publication of the revision to the *Code of State Regulations*.

**T**he agency is also required to make a brief summary of the general nature and extent of comments submitted in support of or opposition to the proposed rule and a concise summary of the testimony presented at the hearing, if any, held in connection with the rulemaking, together with a concise summary of the agency's findings with respect to the merits of any such testimony or comments which are opposed in whole or in part to the proposed rule. The ninety-(90-) day period during which an agency shall file its order of rulemaking for publication in the *Missouri Register* begins either: 1) after the hearing on the proposed rulemaking is held; or 2) at the end of the time for submission of comments to the agency. During this period, the agency shall file with the secretary of state the order of rulemaking, either putting the proposed rule into effect, with or without further changes, or withdrawing the proposed rule.

**Title 1—OFFICE OF ADMINISTRATION**  
**Division 20—Personnel Advisory Board and Division of Personnel**  
**Chapter 5—Working Hours, Holidays, and Leaves of Absence**

**ORDER OF RULEMAKING**

By the authority vested in the Personnel Advisory Board under section 36.070, RSMo Supp. 2021, and section 36.350, RSMo 2016, the board amends a rule as follows:

1 CSR 20-5.020 is amended.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on February 15, 2022 (47 MoReg 225-230). Those sections with changes are reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

**SUMMARY OF COMMENTS:** A public hearing on this proposed amendment was held April 12, 2022, and the public comment period also ended April 12, 2022. The Personnel Advisory Board received one (1) comment on the proposed amendment.

**COMMENT #1:** Department staff commented suggesting that step-grandparents be included along with the other new additions to the bereavement leave policy from the proposed amendment.

**RESPONSE AND EXPLANATION OF CHANGE:** As a result of this comment, step-grandparents of an employee or an employee's spouse have now been included. The description of family members included in this policy has also been simplified.

**1 CSR 20-5.020 Leaves of Absence**

(8) Time off with compensation shall be governed by the following provisions:

(B) With the approval of the appointing authority, an employee may be granted time off from duty, with compensation, for any of the following reasons:

1. Attendance at professional conferences, institutes, or meetings when attendance, in the opinion of the appointing authority, may be expected to contribute to the betterment of the service. Proof of actual attendance at these meetings may be required by the appointing authority;

2. Attendance at in-service training and other courses designed to improve the employee's performance or to prepare the employee for advancement;

3. Absence, not to exceed five (5) consecutive workdays, due to the bereavement of an employee as a result of the death of the spouse, child, sibling, parent, grandparent or grandchild of the employee or employee's spouse, or a member of the employee's household. This shall include half- and step-relatives. The final decision concerning the applicability and length of such leave under this section shall rest with the appointing authority. Other absences due to the death of loved ones, when approved by the appointing authority, shall be charged to an employee's accumulated annual or compensatory leave;

4. Leaves of absence for five (5) workdays to serve as a bone marrow donor and leaves of absence for thirty (30) workdays to serve as a human organ donor as defined in section 105.266, RSMo. Leave is authorized under these circumstances only when the employee is serving as the donor and written verification is provided to the appointing authority; and

5. Because of extraordinary reasons sufficient in the opinion of the appointing authority to warrant such time off with compensation.

*REVISED PUBLIC COST: The cost to state agencies or political subdivisions is estimated to be sixty-three thousand one hundred eighty-two dollars and forty-six cents (\$63,182.46) annually in the aggregate, versus the thirty-five thousand nine hundred thirty-three dollars and eleven cents (\$35,933.11) annually in the aggregate which was submitted with the proposed amendment.*



**REVISED FISCAL NOTE  
PUBLIC COST**

- I. Department Title: Office of Administration  
Division Title: Personnel Advisory Board and Division of Personnel  
Chapter Title: Working Hours, Holidays and Leaves of Absence**

<b>Rule Number and Name:</b>	1 CSR 20-5.020 Leaves of Absence
<b>Type of Rulemaking:</b>	Order of Rulemaking

**II. SUMMARY OF FISCAL IMPACT**

<b>Affected Agency or Political Subdivision</b>	<b>Estimated Cost of Compliance in the Aggregate</b>
Office of Administration	\$3,221.65 annually
Dept. of Agriculture	\$621.68 annually
Dept. of Commerce and Insurance	\$1,503.34 annually
Dept. of Conservation	\$2,246.62 annually
Dept. of Corrections	\$10,991.07 annually
Dept. of Economic Development	\$418.49 annually
Dept. of Elementary and Secondary Education	\$2,523.71 annually
Dept. of Health and Senior Services	\$2,686.47 annually
Dept. of Higher Education and Workforce Development	\$503.55 annually
Dept. of Labor and Industrial Relations	\$1,032.43 annually
Dept. of Mental Health	\$8,740.99 annually
Dept. of Natural Resources	\$2,610.14 annually
Dept. of Public Safety	\$8,525.05 annually
Dept. of Revenue	\$1,498.57 annually
Dept. of Social Services	\$7,937.63 annually
Dept. of Transportation	\$8,121.07 annually
<b>Total</b>	<b>\$63,182.46 annually</b>

**III. WORKSHEET**

227,267      Average number of bereavement leave hours used statewide in fiscal years  
2019-2021 (217,972, 224,157, 239,672)

\*

0.05      See Assumption 1

=

11,363.35      Expected additional bereavement leave hours per year

11,363.35      Expected additional bereavement leave hours per year

\*

0.5      See Assumption 5

\*

0.5      See Assumption 6

=

2,840.84      Reduced annual leave usage per year as a result of bereavement leave  
expansion

2,840.84      Reduced annual leave usage per year

\*

0.98      See Assumption 7

=

2,784.02      Total cost in annual leave hours

*Explanation: Annual leave hours that would have been taken absent this policy change, and that would not have lapsed at some later time, represent hours that must be liquidated and paid out to employees upon separation from state employment. In the absence of bereavement leave expansion, these annual leave hours would have been used by the employee and would not have been paid out upon separation, so they represent the projected public cost per year of bereavement leave expansion.*

State Agency	Employees	Avg. Salary	Estimated Cost of Compliance
Office of Administration	1,684	\$24.34	\$3,221.65
Dept. of Agriculture	361	\$21.91	\$621.68
Dept. of Commerce and Insurance	693	\$27.60	\$1,503.34
Dept. of Conservation	1,459	n/a	\$2,246.62*
Dept. of Corrections	8,250	\$16.95	\$10,991.07
Dept. of Economic Development	232	\$22.95	\$418.49
Dept. of Elementary and Secondary Education	1,511	\$21.25	\$2,523.71
Dept. of Health and Senior Services	1,578	\$21.66	\$2,686.47
Dept. of Higher Education and Workforce Development	317	\$20.21	\$503.55

Dept. of Labor and Industrial Relations	607	\$21.64	\$1,032.43
Dept. of Mental Health	6,199	\$17.94	\$8,740.99
Dept. of Natural Resources	1,472	\$22.56	\$2,610.14
Dept. of Public Safety	4,827	\$22.47	\$8,525.05
Dept. of Revenue	1,104	\$17.27	\$1,498.57
Dept. of Social Services	5,623	\$17.96	\$7,937.63
Dept. of Transportation	5,115	\$20.20	\$8,121.07
<b>Total</b>	<b>41,032</b>	<b>n/a</b>	<b>\$63,182.46</b>

*Explanation: Estimated cost is calculated by multiplying the agency's average salary amongst employees who took bereavement leave in fiscal year 2021 by the 2% COLA effective January 1, 2022, by the 5.5% across-the-board salary increase in the fiscal year 2023 budget, by the agency's percentage share of total state employment, by the total annual leave hours figure calculated above, and then by 1.0765 to account for the additional employer share of Medicare and Social Security taxes. Annual leave payouts made upon separation from state employment do not include employer contributions to any other fringe benefits.*

*\* Department of Conservation bereavement leave usage data is not available to the Office of Administration in the SAM II system. The estimate for this state agency has been calculated using the average per capita estimated cost at the other 15 state agencies.*

#### IV. ASSUMPTIONS

##### A. Demographic Assumptions

- 1) The 13 existing categories of deaths causing an employee to be eligible to take bereavement leave (employee's spouse, child, sibling, parent, step-parent, grandparent, or grandchild; spouse's child, parent, step-parent, grandparent, or grandchild; or a member of the employee's household), on average, have larger populations and higher mortality rates than the five new categories of eligibility (employee's step-sibling and step-grandparent and spouse's sibling, step-sibling, and step-grandparent). This expanded eligibility will result in no more than five percent more eligible deaths per year.
- 2) The frequency of the occurrence of an eligible death and the average length of bereavement leave taken per eligible death will be the same going forward across all state agencies.
- 3) Average salary was calculated by averaging the salary of the employees who took bereavement leave at each state agency in fiscal year 2021. This average is a better estimate than using the agency-wide average salary or the statewide average salary.

##### B. Leave Usage Assumptions

- 4) Employees will be equally likely to take bereavement leave for the death of a step-sibling or step-grandparent or spouse's sibling, step-sibling, or step-grandparent as they are to take bereavement leave for the 13 existing categories of deaths eligible for bereavement leave and will take, on average, an equal number of leave hours.

- 5) Prior to this expansion of bereavement leave, employees would have had to take annual leave in instances of death of a step-sibling or step-grandparent or spouse's sibling, step-sibling, or step-grandparent because bereavement leave was unavailable. With bereavement leave now available, employees will be twice as likely to decide to take leave time.
- 6) Prior to this expansion of bereavement leave, employees would have had to take annual leave in instances of death of a step-sibling or step-grandparent or spouse's sibling, step-sibling, or step-grandparent because bereavement leave was unavailable. With bereavement leave now available, those employees who would have decided to take annual leave previously would have used 50% fewer hours of leave per eligible death than they will going forward with bereavement leave now available.
- 7) 2% of annual leave that is retained because of this bereavement leave expansion will ultimately lapse pursuant to the leave sweep provision of 1 CSR 20-5.020(1)(D).
- 8) State agencies will not hire part-time employees and will not incur additional overtime costs in absorbing the duties of employees taking bereavement leave that would not have been taken prior to this expansion.
- 9) The possession of more annual leave that previously would have been used to take time off for an ineligible death will not impact future annual leave usage by an employee.

#### **C. General Assumptions**

- 10) The average employee salaries used for these calculations is adjusted for the 2% cost-of-living adjustment effective January 1, 2022 and the 5.5% across-the-board salary increase in the fiscal year 2023 budget, but is not adjusted for any other salary adjustments or in anticipation of uncertain future salary adjustments.
- 11) Employee headcount data in total and at each state agency is taken from the SAM II Talent Management Dashboard as of November 30, 2021. Future employee headcount is not adjusted in anticipation of uncertain future increases or decreases in staffing.
- 12) The provisions of 1 CSR 20-5.020 relating to bereavement leave apply to all 16 executive agencies pursuant to section 36.350, RSMo. Any elected officials or other branches of government that choose to follow this regulation do so voluntarily, and the fiscal impact of those choices is not part of the fiscal impact of this proposed amendment.

**Title 8—DEPARTMENT OF LABOR AND  
INDUSTRIAL RELATIONS  
Division 20—Labor and Industrial Relations Commission  
Chapter 2—General Rules**

**ORDER OF RULEMAKING**

By the authority vested in the Labor and Industrial Relations Commission under section 286.060, RSMo 2016, the commission amends a rule as follows:

**8 CSR 20-2.010 Governing Rules is amended.**

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on March 15, 2022 (47 MoReg 413-414). No changes have been made in the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

**Title 8—DEPARTMENT OF LABOR AND  
INDUSTRIAL RELATIONS  
Division 20—Labor and Industrial Relations Commission  
Chapter 3—Rules Relating to Division of Workers’  
Compensation**

**ORDER OF RULEMAKING**

By the authority vested in the Labor and Industrial Relations Commission under section 286.060, RSMo 2016, the commission amends a rule as follows:

**8 CSR 20-3.030 Review of Awards or Orders Issued by  
Administrative Law Judges is amended.**

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on March 15, 2022 (47 MoReg 414-415). No changes have been made in the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

**Title 11—DEPARTMENT OF PUBLIC SAFETY  
Division 70—Division of Alcohol and Tobacco Control  
Chapter 2—Rules and Regulations**

**ORDER OF RULEMAKING**

By the authority vested in the Department of Public Safety, Division of Alcohol and Tobacco Control, under section 311.660, RSMo Supp. 2021, the division amends a rule as follows:

**11 CSR 70-2.010 is amended.**

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on March 1, 2022 (47 MoReg 310-311). Those sections with changes are reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: The Division of Alcohol and Tobacco Control received eleven (11) comments on the proposed amendment.

COMMENT #1: Charles Smarr, Stephen Rehagen, Mike Schler, Karen Dorton, and Lorene Williams, with Brydon, Swearngen & England, stated that the proposed language in 11 CSR 70-2.010(1) should be modified to replace the term “line of sight” with the term “ten miles.” They stated that the term “line of sight” is subjective and that TTB has implemented a “ten mile” policy for the last thirty years.

RESPONSE: The term “line of sight” means an observer can stand at Point A and see Point B. The division does not believe this term is subjective. Additionally, the term “line of sight” only comes into effect if the areas are not located on one continuous tract of land or adjoining tracts of land owned by the same person. As for adopting TTB’s “ten mile” standard, the “ten mile” policy is an internal policy that is not codified in any federal statute or regulation. TTB applies this “ten mile” policy to locations that are “within reasonable proximity” and “in the same general area.” Since the term “close proximity” implies a stronger connection and intimacy than “reasonable proximity” or “same general area,” TTB’s internal “ten mile” policy should not be used to define the term “close proximity” used in Missouri Liquor Law. Moreover, the “ten mile” policy applies to multiple manufacturing locations under a single federal permit. Under Missouri Liquor Control Law, the term “close proximity” is mainly used to describe the distance between a retail establishment and a manufacturer facility with common ownership. For these reasons, no changes have been made to the amendment as a result of this comment.

COMMENT #2: Charles Smarr, Stephen Rehagen, Mike Schler, Karen Dorton, and Lorene Williams, with Brydon, Swearngen & England, asked for clarification in 11 CSR 70-2.010(2) regarding the purpose of defining the term “delivery.”

RESPONSE: The purpose of this definition is to distinguish deliveries from shipments. Since no change was requested, no changes have been made to the amendment as a result of this comment.

COMMENT #3: Charles Smarr, Stephen Rehagen, Mike Schler, Karen Dorton, and Lorene Williams, with Brydon, Swearngen & England, stated that the proposed language in 11 CSR 70-2.010(3) should be modified to address beneficiaries of a trust, since beneficiaries are not expressly listed in the statutory definition of “person” in section 311.030, RSMo.

RESPONSE: The division cannot use regulation to expand or modify the statutory definition of “person” in section 311.030, RSMo. While the statutory definition of “person” does not expressly include beneficiaries, it does include any individual or association. Thus, beneficiaries who are individuals or associations of individuals would be covered by the statutory definition of “person” and may have a financial interest in a trust, depending on the nature and structure of the trust. For these reasons, no changes have been made to the amendment as a result of this comment.

COMMENT #4: Charles Smarr, Stephen Rehagen, Mike Schler, Karen Dorton, and Lorene Williams, with Brydon, Swearngen & England, stated that the proposed language in 11 CSR 70-2.010(6) would be very prohibitive and would prohibit spouses from investing in different tiers of the alcohol industry. They further stated that the proposed language should be modified to reflect definitions used in other states that are less restrictive and prohibitive, and to include a “grandfather clause” for existing licensees.

RESPONSE: The division has reviewed the comment and determined that the proposed definition of “indirect financial interest” adequately balances the goals of industry and the requirements of the three-tier system established by Missouri Liquor Control Law. The division is unaware of any conflict between the definition proposed in this amendment and any other state’s statutory or regulatory definition of the term “indirect financial interests.” Finally, the division does not have the statutory authority to include “grandfather clauses” for basic licensure qualifications. For these reasons, no changes have

been made to the amendment as a result of this comment.

**COMMENT #5:** Charles Smarr, Stephen Rehagen, Mike Schler, Karen Dorton, and Lorene Williams, with Brydon, Swearingen & England, stated that the proposed language in 11 CSR 70-2.010(17) regarding the delineation of the licensed premises would require some sort of fencing in every situation.

**RESPONSE:** Licensees are responsible for what happens on their licensed premises, so it's important for employees and customers alike to be able to understand and identify the confines of the licensed premises. The proposed amendment will require licensees to have readily discernable boundaries that employees and customers alike can identify. However, licensees are not required to utilize or install fencing to delineate these boundaries. For these reasons, no changes have been made to the amendment as a result of this comment.

**COMMENT #6:** Charles Smarr, Stephen Rehagen, Mike Schler, Karen Dorton, and Lorene Williams, with Brydon, Swearingen & England, asked for clarification in 11 CSR 70-2.010(19) regarding the purpose of defining the term "shipment."

**RESPONSE:** The purpose of this definition is to distinguish shipments from deliveries. Since no change was requested, no changes have been made to the amendment as a result of this comment.

**COMMENT #7:** Clayton Weems, with the Division of Alcohol and Tobacco Control, stated that the proposed language in 11 CSR 70-2.010(25)(A) and (26) should be modified so that the term "entity" is not defined twice.

**RESPONSE AND EXPLANATION OF CHANGE:** New subsection (25)(A) has been removed so that term "entity" is only defined in new section (26) in order to avoid potential confusion.

**COMMENT #8:** Clayton Weems, with the Division of Alcohol and Tobacco Control, stated that the proposed language in 11 CSR 70-2.010(25)(B) and (27) should be modified so that the term "partnership" is not defined twice.

**RESPONSE AND EXPLANATION OF CHANGE:** New subsection (25)(B) has been removed so that term "partnership" is only defined in new section (27) in order to avoid potential confusion.

**COMMENT #9:** Clayton Weems, with the Division of Alcohol and Tobacco Control, stated that the proposed language in 11 CSR 70-2.010(25)(C) and (28) should be modified so that the term "sole proprietor" is not defined twice.

**RESPONSE AND EXPLANATION OF CHANGE:** New subsection (25)(C) has been removed so that term "sole proprietor" is only defined in new section (28) in order to avoid potential confusion.

**COMMENT #10:** Charles Smarr, Stephen Rehagen, Mike Schler, Karen Dorton, and Lorene Williams, with Brydon, Swearingen & England, and Clayton Weems, with the Missouri Division of Alcohol and Tobacco Control, stated that the proposed language in 11 CSR 70-2.010(26), (27), and (28) should be modified to remove or modify the phrase "legal personality" since it is not a commonly used phrase and may cause confusion.

**RESPONSE AND EXPLANATION OF CHANGE:** The division has removed the phrase "and is considered a legal personality" from 11 CSR 70-2.010(26), (27), and (28) to mitigate potential confusion.

**COMMENT #11:** Charles Smarr, Stephen Rehagen, Mike Schler, Karen Dorton, and Lorene Williams, with Brydon, Swearingen & England, and Clayton Weems, with the Missouri Division of Alcohol and Tobacco Control, stated that the proposed language in 11 CSR 70-2.010(27) and (28) should be modified to clarify whether an LLLP with one person constitutes a "partnership" and to replace to term "persons" with "individuals" to mitigate any potential confusion.

**RESPONSE AND EXPLANATION OF CHANGE:** Since an LLLP

with only one general partner and no limited partners would still be able to qualify for licensure as an "entity" or "sole proprietorship," no change was made to expressly include LLLPs with only one general partnership in the definition of "partnership." The division has replaced the term "persons" with the term "individuals" in 11 CSR 70-2.010(27) and (28) to mitigate any potential confusion.

## 11 CSR 70-2.010 Definitions

(25) Applicant refers to the sole proprietor, partnership, or entity applying for a liquor license.

(26) Entity refers to any association, corporation, limited liability company, limited partnership, or other business structure which has a separate legal existence from its owner(s). Entity also includes any business structure not in conformance with a sole proprietor or partnership structure as defined herein.

(27) Partnership refers to two (2) or more individuals who share control over the management and profits of a business structure. The business has no separate legal existence from the partners.

(28) Sole proprietor refers to one (1) individual who exercises exclusive control over the management and profits of a business structure. The business has no separate existence from its owner. Income and losses are taxed on the individual's personal income tax return.

## Title 11—DEPARTMENT OF PUBLIC SAFETY Division 70—Division of Alcohol and Tobacco Control Chapter 2—Rules and Regulations

### ORDER OF RULEMAKING

By the authority vested in the Department of Public Safety, Division of Alcohol and Tobacco Control, under section 311.660, RSMo Supp. 2021, the division amends a rule as follows:

#### 11 CSR 70-2.020 Application for License is amended.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on March 1, 2022 (47 MoReg 311-312). No changes have been made in the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

**SUMMARY OF COMMENTS:** The Division of Alcohol and Tobacco Control received two (2) comments on the proposed amendment.

**COMMENT #1:** Charles Smarr, Stephen Rehagen, Mike Schler, Karen Dorton, and Lorene Williams, with Brydon, Swearingen & England, questioned the necessity for the proposed language in 11 CSR 70-2.020(10) that allows the supervisor to discipline any licensee who failed to present all documentation and information listed on the checklist of requirements, since the supervisor can simply deny the applicant upfront.

**RESPONSE:** If the supervisor issued a license to an applicant who hid, falsified, or otherwise failed to provide documents or information listed on the checklist of requirements, discipline would be the appropriate remedy. The supervisor cannot deny an application after a license has been issued. For these reasons, no changes have been made to the amendment as a result of this comment.

**COMMENT #2:** Charles Smarr, Stephen Rehagen, Mike Schler, Karen Dorton, and Lorene Williams, with Brydon, Swearingen & England, requested clarification as to whether the division wants to obtain city and county liquor licenses and health inspection reports

after liquor licenses are issued, and whether the division is unwilling to receive applications without all documents and information required by the checklist of requirements.

RESPONSE: The division currently requires licensees to provide proof of city/county licensure pursuant to section 311.220.3, RSMo, and health inspections pursuant to 11 CSR 70-2.060 and 11 CSR 70-2.120. Finally, when the division receives applications that are missing documents or information required by the checklist of requirements, the division works with said applicants to obtain said documents and information and remedy any curable defects. However, the division does not approve incomplete applications. For these reasons, no changes have been made to the amendment as a result of this comment.

**Title 11—DEPARTMENT OF PUBLIC SAFETY  
Division 70—Division of Alcohol and Tobacco Control  
Chapter 2—Rules and Regulations**

**ORDER OF RULEMAKING**

By the authority vested in the Department of Public Safety, Division of Alcohol and Tobacco Control, under section 311.660, RSMo Supp. 2021, the division amends a rule as follows:

**11 CSR 70-2.030 Change of Facts, Posting, Transfer, and Lost Licenses—Executors—Administrators is amended.**

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on March 1, 2022 (47 MoReg 312-313). No changes have been made in the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: The Division of Alcohol and Tobacco Control received one (1) comment on the proposed amendment.

COMMENT #1: Charles Smarr, Stephen Rehagen, Mike Schler, Karen Dorton, and Lorene Williams, with Brydon, Swearngen & England, stated the proposed language in 11 CSR 70-2.030(2) would require licensees to obtain city and county licensure, which may be impossible if a city or county does not issue licenses.

RESPONSE: 11 CSR 70-2.030(2), as amended, requires licensees to display licenses issued by the supervisor as well as “any city or county license designating the premises as a place to sell intoxicating liquor.” It does not require procuring city or county licenses that are not otherwise required. For these reasons, no changes have been made to the amendment as a result of this comment.

**Title 11—DEPARTMENT OF PUBLIC SAFETY  
Division 70—Division of Alcohol and Tobacco Control  
Chapter 2—Rules and Regulations**

**ORDER OF RULEMAKING**

By the authority vested in the Department of Public Safety, Division of Alcohol and Tobacco Control, under section 311.660, RSMo Supp. 2021, the division amends a rule as follows:

**11 CSR 70-2.050 Wholesalers’ Conduct of Business is amended.**

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on March 1, 2022 (47 MoReg 313-314). No changes have been made in the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the

*Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

**Title 11—DEPARTMENT OF PUBLIC SAFETY  
Division 70—Division of Alcohol and Tobacco Control  
Chapter 2—Rules and Regulations**

**ORDER OF RULEMAKING**

By the authority vested in the Department of Public Safety, Division of Alcohol and Tobacco Control, under section 311.660, RSMo Supp. 2021, the division amends a rule as follows:

11 CSR 70-2.060 is amended.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on March 1, 2022 (47 MoReg 314-315). Those sections with changes are reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: The Division of Alcohol and Tobacco Control received three (3) comments on the proposed amendment.

COMMENT #1: Charles Smarr, Stephen Rehagen, Mike Schler, Karen Dorton, and Lorene Williams, with Brydon, Swearngen & England, stated that the proposed language in 11 CSR 70-2.060(1)(B) should be modified so that natural persons possessing a licensed entity are also deemed owners.

RESPONSE AND EXPLANATION OF CHANGE: The division has expanded the proposed amendment to apply to persons and entities. This change should clarify that natural persons are also considered owners.

COMMENT #2: Sarah Schappe with JCAR instructed the division to follow the requirements found in sections 536.021 and 536.031, RSMo to properly incorporate the federal act by reference in 11 CSR 70-2.060(2).

RESPONSE AND EXPLANATION OF CHANGE: The division has added the proper reference to incorporate the Federal Alcohol Administration Act into this regulation.

COMMENT #3: The division received a comment from staff regarding subsection (3)(A). Staff noted that the “and” at the end of subsection (3)(A) should be “or.”

RESPONSE AND EXPLANATION OF CHANGE: The division agrees with the comment and has changed “and” to “or” in subsection (3)(A).

**11 CSR 70-2.060 Manufacturers**

(1) For the purpose of this regulation the following definitions apply:

(B) An “owner” of a facility which brews or manufactures malt liquor is defined as a person or entity, that holds the entire facility in fee simple, or has a leasehold interest for a term of years in that entire facility, and is the person or business entity licensed for that entire facility by either or both the state within which the facility is located and/or the U.S. Treasury Department, Alcohol and Tobacco Tax and Trade Bureau.

(2) The Federal Alcohol Administration Act is hereby incorporated by reference (published by the United States House, dated January 1, 2022 and available at: <https://uscode.house.gov/view.xhtml?path=/prelim@title27/chapter8&edition=prelim>). This does not include any later amendments or additions. These regulations apply to distilled spirits, wine, and

malt beverages packaged purely for interstate shipment insofar as the regulations are not contrary to or inconsistent with the laws of Missouri. In addition to the regulations, the label of every container of spirituous liquor, wine, or malt liquor, unless already required by the regulations, shall set forth the name and address of the manufacturer, brewer, distiller, rectifier, or producer of the spirituous liquor, wine, or malt liquor as the case may be; provided that if the name of the brewer or manufacturer of malt liquor which appears on the label is not the owner of the facility where the malt liquor was brewed or manufactured, then the name, owner, and address of the facility shall also be set forth on the label.

(3) All licensees engaged in bottling intoxicating liquor and alcoholic beverages, before filling any bottle, shall cause the same to be sterilized by one (1) of the following methods:

(A) All new bottles, unless sterile, are to be sterilized or cleaned by thoroughly rinsing with clean sterile water or by blowing or vacuuming with proper machines for sterilization or cleansing; or

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Chapter 2—Rules and Regulations**

**ORDER OF RULEMAKING**

By the authority vested in the Department of Public Safety, Division of Alcohol and Tobacco Control, under section 311.660, RSMo Supp. 2021, the division amends a rule as follows:

11 CSR 70-2.070 is amended.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on March 1, 2022 (47 MoReg 315). Those sections with changes are reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: The Division of Alcohol and Tobacco Control received one (1) comment on the proposed amendment.

COMMENT #1: Charles Smarr, Stephen Rehagen, Mike Schler, Karen Dorton, and Lorene Williams, with Brydon, Swearngen & England, stated that the proposed language in 11 CSR 70-2.070(3) should be modified so that solicitors, off-site storage facilities licensed by solicitors, and unlicensed storage facilities can possess untaxed spirituous liquor or wines.

RESPONSE AND EXPLANATION OF CHANGE: The division has added solicitors to the list of licensed persons who are able to possess untaxed spirituous liquor and wines. However, the division has not added off-site storage facilities licensed by solicitors or unlicensed storage facilities. When a solicitor obtains permission to utilize off-site storage facilities, those off-site storage facilities are treated as an extension of the solicitor's licensed premises. Solicitors can store intoxicating liquor anywhere on their licensed premises, so adding off-site storage facilities licensed by solicitors is unnecessary. As for unlicensed storage facilities, any person—licensed or otherwise—can utilize these facilities as long as they comply with section 311.370, RSMo. However, unlicensed storage facilities cannot possess any form of untaxed intoxicating liquor unless they qualify under section 311.580, RSMo.

**11 CSR 70-2.070 Tax on Spirituous Liquor and Wine**

(3) No person other than a licensed distiller, rectifier, wine manufacturer, or solicitor may possess in this state any spirituous liquor or wines without the proper amount of taxes having been paid, except as provided in section 311.580, RSMo.

**Title 11—DEPARTMENT OF PUBLIC SAFETY  
Division 70—Division of Alcohol and Tobacco Control  
Chapter 2—Rules and Regulations**

**ORDER OF RULEMAKING**

By the authority vested in the Department of Public Safety, Division of Alcohol and Tobacco Control, under section 311.660, RSMo Supp. 2021, the division amends a rule as follows:

11 CSR 70-2.080 is amended.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on March 1, 2022 (47 MoReg 315-316). Those sections with changes are reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: The Division of Alcohol and Tobacco Control received one (1) comment on the proposed amendment.

COMMENT #1: Charles Smarr, Stephen Rehagen, Mike Schler, Karen Dorton, and Lorene Williams, with Brydon, Swearngen & England, stated that the proposed language in 11 CSR 70-2.080(3) should be modified so that solicitors, off-site storage facilities licensed by solicitors, and unlicensed storage facilities can possess untaxed malt liquor.

RESPONSE AND EXPLANATION OF CHANGE: The division has added solicitors to the list of licensed persons who are able to possess untaxed malt liquor. However, the division has not added off-site storage facilities licensed by solicitors or unlicensed storage facilities. When a solicitor obtains permission to utilize off-site storage facilities, those off-site storage facilities are treated as an extension of the solicitor's licensed premises. Solicitors can store intoxicating liquor anywhere on their licensed premises, so adding off-site storage facilities licensed by solicitors is unnecessary. As for unlicensed storage facilities, any person—licensed or otherwise—can utilize these facilities as long as they comply with section 311.370, RSMo. However, unlicensed storage facilities cannot possess any form of untaxed intoxicating liquor unless they qualify under section 311.580, RSMo.

**11 CSR 70-2.080 Malt Liquor Tax**

(3) No person other than a licensed brewer, malt liquor manufacturer, or solicitor may possess in this state any malt liquor without the proper amount of taxes having been paid, except as provided in section 311.580, RSMo.

**Title 11—DEPARTMENT OF PUBLIC SAFETY  
Division 70—Division of Alcohol and Tobacco Control  
Chapter 2—Rules and Regulations**

**ORDER OF RULEMAKING**

By the authority vested in the Department of Public Safety, Division of Alcohol and Tobacco Control, under section 311.660, RSMo Supp. 2021, the division amends a rule as follows:

**11 CSR 70-2.090 Reports of Distillers, Solicitors, Wine Manufacturers, and Wholesalers is amended.**

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on March 1, 2022 (47 MoReg 316). No changes have been made in the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.



SUMMARY OF COMMENTS: The Division of Alcohol and Tobacco Control received one (1) comment on the proposed amendment.

COMMENT #1: Charles Smarr, Stephen Rehagen, Mike Schler, Karen Dorton, and Lorene Williams, with Brydon, Swearngen & England, stated that the proposed language in 11 CSR 70-2.090(1) only gives licensees fifteen (15) days to report any changes, which may be a short time if what has been requested is voluminous.

RESPONSE: Licensees currently have ten (10) days to report the information required by 11 CSR 70-2.090(1). The division has extended that time to fifteen (15) days, which will give licensees more time to report the required information. Additionally, the fifteen (15) day time frame does not start until the effective date of the change. Licensees who are aware of changes ahead of the effective day will have more than fifteen (15) days to compile and transmit the required information. Finally, this fifteen- (15-) day requirement is consistent with the change of fact reporting requirement in 11 CSR 70-2.030(1). The division does not believe that any further extensions are necessary at this time. For these reasons, no changes have been made to the amendment as a result of this comment.

**Title 11—DEPARTMENT OF PUBLIC SAFETY  
Division 70—Division of Alcohol and Tobacco Control  
Chapter 2—Rules and Regulations**

**ORDER OF RULEMAKING**

By the authority vested in the Department of Public Safety, Division of Alcohol and Tobacco Control, under section 311.660, RSMo Supp. 2021, the division amends a rule as follows:

**11 CSR 70-2.100 Report of Brewers, Beer Manufacturers,  
Solicitors, and Beer Wholesalers is amended.**

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on March 1, 2022 (47 MoReg 317). No changes have been made in the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: The Division of Alcohol and Tobacco Control received one (1) comment on the proposed amendment.

COMMENT #1: Charles Smarr, Stephen Rehagen, Mike Schler, Karen Dorton, and Lorene Williams, with Brydon, Swearngen & England, stated that the proposed language in 11 CSR 70-2.100(3) only gives licensees fifteen (15) days to take any corrective action, which may be a short time if what has been requested is voluminous.

RESPONSE: These reports must be filed monthly, and are therefore time-sensitive. If a report is missing, incomplete, or inaccurate, it is important for licensees to rectify those errors quickly. Failure to rectify those errors quickly can create errors in future reports, causing downstream ramifications for both licensees and the division. Moreover, distillers and wine manufacturers will have the same fifteen- (15-) day reporting requirement under 11 CSR 70-2.090, so this amendment will result in consistency for all licensees. For these reasons, no changes have been made to the amendment as a result of this comment.

**Title 19—DEPARTMENT OF HEALTH AND SENIOR  
SERVICES**

**Division 15—Division of Senior and Disability Services  
Chapter 4—Older Americans Act**

**ORDER OF RULEMAKING**

By the authority vested in the Department of Health and Senior

Services under section 192.2000, RSMo 2016, the department amends a rule as follows:

19 CSR 15-4.010 is amended.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on March 1, 2022 (47 MoReg 331-334). Those sections with changes are reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: The Department of Health and Senior Services received four (4) comments on the proposed amendment.

COMMENT #1: The Missouri Association of Area Agencies on Aging suggested further defining facility in the definition of focal point in section (32).

RESPONSE: The focal point definition is consistent with the definition in the Older Americans Act. No changes have been made to the amendment as a result of this comment.

COMMENT #2: The Missouri Association of Area Agencies on Aging inquired if Highest Level Evidence-Based Programs (HLEB) defined in section (36) are the only programs eligible under Title III-D of the Older Americans Act (OAA), and is the determination at the discretion of the State Unit on Aging (SUA).

RESPONSE: The Administration for Community Living (ACL) determines the eligibility under Title III-D of the OAA, the SUA does not have discretion as to eligibility determination under Title III-D of the OAA. No changes have been made to the amendment as a result of this comment.

COMMENT #3: The Missouri Association of Area Agencies on Aging inquired if the changes to the definition of information and assistance in section (39) will affect tracking of information and assistance units.

RESPONSE: The changes to the definition of information and assistance will not affect the tracking information and assistance units. No changes have been made to the amendment as a result of this comment.

COMMENT #4: The Missouri Department of Health and Senior Services commented that the term “food stamps” referenced in the definition of “contributions” in section (25) should be changed to “Supplemental Nutrition Assistance Program (SNAP)” to reflect the correct terminology.

RESPONSE AND EXPLANATION OF CHANGE: The department reviewed the comment and will change “food stamps” to “Supplemental Nutrition Assistance Program (SNAP)” in section (25), to reflect the correct terminology of the name of the program.

**19 CSR 15-4.010 Definition of Terms**

(25) Contributions—Money or Supplemental Nutrition Assistance Program (SNAP) (for meals only) given voluntarily and confidentially toward the cost of a service received.

**Title 19—DEPARTMENT OF HEALTH AND SENIOR  
SERVICES**

**Division 15—Division of Senior and Disability Services  
Chapter 4—Older Americans Act**

**ORDER OF RULEMAKING**

By the authority vested in the Department of Health and Senior Services under section 192.2000, RSMo 2016, the department amends a rule as follows:

**19 CSR 15-4.020 Administration of the Older Americans Act  
is amended.**

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on March 1, 2022 (47 MoReg 334-335). No changes have been made in the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

**Title 19—DEPARTMENT OF HEALTH AND SENIOR  
SERVICES  
Division 15—Division of Senior and Disability Services  
Chapter 4—Older Americans Act****ORDER OF RULEMAKING**

By the authority vested in the Department of Health and Senior Services under section 192.2000, RSMo 2016, the department amends a rule as follows:

**19 CSR 15-4.040 State Plan is amended.**

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on March 1, 2022 (47 MoReg 335). No changes have been made in the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

**Title 19—DEPARTMENT OF HEALTH AND SENIOR  
SERVICES  
Division 15—Division of Senior and Disability Services  
Chapter 4—Older Americans Act****ORDER OF RULEMAKING**

By the authority vested in the Department of Health and Senior Services under section 192.2000, RSMo 2016, the department amends a rule as follows:

**19 CSR 15-4.050 Funding Formula and Fiscal Management  
is amended.**

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on March 1, 2022 (47 MoReg 335-337). No changes have been made in the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

**Title 19—DEPARTMENT OF HEALTH AND SENIOR  
SERVICES  
Division 15—Division of Senior and Disability Services  
Chapter 4—Older Americans Act****ORDER OF RULEMAKING**

By the authority vested in the Department of Health and Senior Services under section 192.2000, RSMo 2016, and section 192.2305, RSMo Supp. 2021, the department amends a rule as follows:

**19 CSR 15-4.060 State Long-Term Care Ombudsman Program  
is amended.**

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on March 1, 2022 (47 MoReg 337). No changes have been made in the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

**Title 19—DEPARTMENT OF HEALTH AND SENIOR  
SERVICES  
Division 15—Division of Senior and Disability Services  
Chapter 4—Older Americans Act****ORDER OF RULEMAKING**

By the authority vested in the Department of Health and Senior Services under section 192.2000, RSMo 2016, the department amends a rule as follows:

**19 CSR 15-4.070 Designation of Area Agencies on Aging  
is amended.**

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on March 1, 2022 (47 MoReg 337-338). No changes have been made in the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

**Title 19—DEPARTMENT OF HEALTH AND SENIOR  
SERVICES  
Division 15—Division of Senior and Disability Services  
Chapter 4—Older Americans Act****ORDER OF RULEMAKING**

By the authority vested in the Department of Health and Senior Services under section 192.2000, RSMo 2016, the department amends a rule as follows:

**19 CSR 15-4.080 Withdrawal of Designation is amended.**

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on March 1, 2022 (47 MoReg 338). No changes have been made in the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: The Department of Health and Senior Services received one (1) comment on the proposed amendment.

COMMENT #1: The Missouri Association of Area Agencies on Aging inquired if the department's authority to withdraw the designation of the area agencies on aging is a conflict of interest. RESPONSE: The rule identifies the circumstances the department may withdraw the designation of an area agency on aging as pursuant to the Older Americans Act and section 192.2000, RSMo. No changes have been made to the amendment as a result of this comment.

**Title 19—DEPARTMENT OF HEALTH AND SENIOR SERVICES**

**Division 15—Division of Senior and Disability Services  
Chapter 4—Older Americans Act**

**ORDER OF RULEMAKING**

By the authority vested in the Department of Health and Senior Services under section 192.2000, RSMo 2016, the department amends a rule as follows:

**19 CSR 15-4.090** Appeal to the Assistant Secretary **is amended**.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on March 1, 2022 (47 MoReg 338-339). No changes have been made in the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

**Title 19—DEPARTMENT OF HEALTH AND SENIOR SERVICES**

**Division 15—Division of Senior and Disability Services  
Chapter 4—Older Americans Act**

**ORDER OF RULEMAKING**

By the authority vested in the Department of Health and Senior Services under section 192.2000, RSMo 2016, the department amends a rule as follows:

**19 CSR 15-4.100** Area Agency on Aging Governing Body **is amended**.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on March 1, 2022 (47 MoReg 339). No changes have been made in the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: The Department of Health and Senior Services received one (1) comment on the proposed amendment.

COMMENT #1: The Missouri Association of Area Agencies on Aging inquired if the intent of the section (8) is that the board should notify the division of all staffing changes within thirty (30) days or is the intent specific to change in agency leadership.

RESPONSE: The rule requires the area agency on aging governing body to notify the division within thirty (30) days of any changes it makes to staff. No changes have been made to the amendment as a result of this comment.

**Title 19—DEPARTMENT OF HEALTH AND SENIOR SERVICES**

**Division 15—Division of Senior and Disability Services  
Chapter 4—Older Americans Act**

**ORDER OF RULEMAKING**

By the authority vested in the Department of Health and Senior Services under section 192.2000, RSMo 2016, the department amends a rule as follows:

**19 CSR 15-4.105** Area Agency on Aging Election Procedures for Governing Body Membership **is amended**.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on March 1, 2022 (47 MoReg 339-340). No changes have been made in the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

**Title 19—DEPARTMENT OF HEALTH AND SENIOR SERVICES**

**Division 15—Division of Senior and Disability Services  
Chapter 4—Older Americans Act**

**ORDER OF RULEMAKING**

By the authority vested in the Department of Health and Senior Services under sections 192.2000 and 192.2020, RSMo 2016, the department amends a rule as follows:

**19 CSR 15-4.110** Area Agency on Aging Advisory Council **is amended**.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on March 1, 2022 (47 MoReg 340). No changes have been made in the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

**Title 19—DEPARTMENT OF HEALTH AND SENIOR SERVICES**

**Division 15—Division of Senior and Disability Services  
Chapter 4—Older Americans Act**

**ORDER OF RULEMAKING**

By the authority vested in the Department of Health and Senior Services under section 192.2000, RSMo 2016, the department amends a rule as follows:

**19 CSR 15-4.120** Affirmative Action/Equal Employment Opportunity/Preference in Hiring **is amended**.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on March 1, 2022 (47 MoReg 340-341). No changes have been made in the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

**Title 19—DEPARTMENT OF HEALTH AND SENIOR SERVICES**

**Division 15—Division of Senior and Disability Services  
Chapter 4—Older Americans Act**

**ORDER OF RULEMAKING**

By the authority vested in the Department of Health and Senior

Services under section 192.2000, RSMo 2016, the department amends a rule as follows:

**19 CSR 15-4.130 Area Agency on Aging Staff is amended.**

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on March 1, 2022 (47 MoReg 341). No changes have been made in the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

**Title 19—DEPARTMENT OF HEALTH AND SENIOR SERVICES**  
**Division 15—Division of Senior and Disability Services**  
**Chapter 4—Older Americans Act**

**ORDER OF RULEMAKING**

By the authority vested in the Department of Health and Senior Services under section 192.2000, RSMo 2016, the department amends a rule as follows:

**19 CSR 15-4.135 Area Agency on Aging Director is amended.**

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on March 1, 2022 (47 MoReg 341). No changes have been made in the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

**Title 19—DEPARTMENT OF HEALTH AND SENIOR SERVICES**  
**Division 15—Division of Senior and Disability Services**  
**Chapter 4—Older Americans Act**

**ORDER OF RULEMAKING**

By the authority vested in the Department of Health and Senior Services under sections 192.2000 and 192.2025, RSMo 2016, the department amends a rule as follows:

**19 CSR 15-4.140 Area Agency on Aging Plan is amended.**

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on March 1, 2022 (47 MoReg 341-342). No changes have been made in the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

**Title 19—DEPARTMENT OF HEALTH AND SENIOR SERVICES**  
**Division 15—Division of Senior and Disability Services**  
**Chapter 4—Older Americans Act**

**ORDER OF RULEMAKING**

By the authority vested in the Department of Health and Senior

Services under section 192.2000, RSMo 2016, the department amends a rule as follows:

**19 CSR 15-4.150 Waivers is amended.**

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on March 1, 2022 (47 MoReg 342). No changes have been made in the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

**Title 19—DEPARTMENT OF HEALTH AND SENIOR SERVICES**  
**Division 15—Division of Senior and Disability Services**  
**Chapter 4—Older Americans Act**

**ORDER OF RULEMAKING**

By the authority vested in the Department of Health and Senior Services under sections 192.2000 and 192.2025, RSMo 2016, the department amends a rule as follows:

**19 CSR 15-4.160 Review, Submission, and Approval of Area Agency on Aging Area Plans and Plan Amendments is amended.**

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on March 1, 2022 (47 MoReg 342-343). No changes have been made in the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

**Title 19—DEPARTMENT OF HEALTH AND SENIOR SERVICES**  
**Division 15—Division of Senior and Disability Services**  
**Chapter 4—Older Americans Act**

**ORDER OF RULEMAKING**

By the authority vested in the Department of Health and Senior Services under section 192.2000, RSMo 2016, the department amends a rule as follows:

**19 CSR 15-4.170 is amended.**

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on March 1, 2022 (47 MoReg 343-344). Those sections with changes are reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: The Department of Health and Senior Services received one (1) comment on the proposed amendment.

COMMENT #1: The Joint Committee on Administrative Rules commented that the references to the *Code of Federal Regulations* (CFR) in subsections (1)(B), (7)(C), (16)(A), (16)(B), and (16)(C) should be incorporated by reference in the rule.

RESPONSE AND EXPLANATION OF CHANGE: The department reviewed and will incorporate by reference the *Code of Federal*

*Regulations* (CFR) in subsections (1)(B), (7)(C), (16)(A), (16)(B), and (16)(C).

**19 CSR 15-4.170 Area Agency on Aging Fiscal Management**

(1) The area agency on aging shall establish a system to monitor financial expenditures of grants and contracts. In order to ensure adequate monitoring, at a minimum, the area agency on aging shall—

(B) Document, through assessment reports, that expenditures are made in accordance with the provisions of 45 CFR Part 75, which has been incorporated by reference in this rule, as published on October 1, 2021, by the Office of the Federal Register, National Archives and Record Administration, 7G Street NW, Suite A-734, Washington, DC 20401-0001 and available at <https://bookstore.gpo.gov/catalog/code-federal-regulations-cfrs-print>. This rule does not incorporate any subsequent amendments or additions;

(7) The area agency on aging shall have an organization-wide audit completed by an independent certified public accountant yearly. Further requirements are as follows:

(C) The criteria to be followed in auditing an area agency on aging shall be for—

1. Governmental agencies, the audit provisions in 2 CFR Part 200, which has been incorporated by reference in this rule, as published on January 1, 2021, by the Office of the Federal Register, National Archives and Record Administration, 7G Street NW, Suite A-734, Washington, DC 20401-0001 and available at <https://bookstore.gpo.gov/catalog/code-federal-regulations-cfrs-print>, shall apply for fiscal years beginning after December 31, 1984. This rule does not incorporate any subsequent amendments or additions; and

2. All other agencies, the audit provisions in 2 CFR Part 200 shall apply; and

(16) Any cost allocation plans and indirect costs rates shall be determined in accordance with the following guidelines:

(A) For governments, 2 CFR Part 255, which has been incorporated by reference in this rule, as published on January 1, 2021, by the Office of the Federal Register, National Archives and Record Administration, 7G Street NW, Suite A-734, Washington, DC 20401-0001 and available at <https://bookstore.gpo.gov/catalog/code-federal-regulations-cfrs-print>, this rule does not incorporate any subsequent amendments or additions, including any amendments published by the United States OMB;

(B) For institutions of higher education, 2 CFR Part 220, which has been incorporated by reference in this rule, as published on January 1, 2021, by the Office of the Federal Register, National Archives and Record Administration, 7G Street NW, Suite A-734, Washington, DC 20401-0001 and available at <https://bookstore.gpo.gov/catalog/code-federal-regulations-cfrs-print> and as published in the *Federal Register* by OMB. This rule does not incorporate any subsequent amendments or additions; and

(C) For other nonprofit organizations, 2 CFR Part 230, which has been incorporated by reference in this rule, as published on January 1, 2021, by the Office of the Federal Register, National Archives and Record Administration, 7G Street NW, Suite A-734, Washington, DC 20401-0001 and available at <https://bookstore.gpo.gov/catalog/code-federal-regulations-cfrs-print>. This rule does not incorporate any subsequent amendments or additions.

**Title 19—DEPARTMENT OF HEALTH AND SENIOR SERVICES**

**Division 15—Division of Senior and Disability Services  
Chapter 4—Older Americans Act**

**ORDER OF RULEMAKING**

By the authority vested in the Department of Health and Senior

Services under section 192.2000, RSMo 2016, the department amends a rule as follows:

**19 CSR 15-4.175 Funding for Establishment, Maintenance, Modernization, Acquisition, or Construction of Multipurpose Senior Centers is amended.**

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on March 1, 2022 (47 MoReg 344-346). No changes have been made in the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

**Title 19—DEPARTMENT OF HEALTH AND SENIOR SERVICES**

**Division 15—Division of Senior and Disability Services  
Chapter 4—Older Americans Act**

**ORDER OF RULEMAKING**

By the authority vested in the Department of Health and Senior Services under section 192.2000, RSMo 2016, the department amends a rule as follows:

**19 CSR 15-4.180 Area Agency on Aging Advocacy Responsibility is amended.**

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on March 1, 2022 (47 MoReg 346). No changes have been made in the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

**Title 19—DEPARTMENT OF HEALTH AND SENIOR SERVICES**

**Division 15—Division of Senior and Disability Services  
Chapter 4—Older Americans Act**

**ORDER OF RULEMAKING**

By the authority vested in the Department of Health and Senior Services under section 192.2000, RSMo 2016, the department amends a rule as follows:

**19 CSR 15-4.190 Area Agency on Aging Development of a Comprehensive and Coordinated Service Delivery System is amended.**

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on March 1, 2022 (47 MoReg 346-347). No changes have been made in the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

**Title 19—DEPARTMENT OF HEALTH AND SENIOR SERVICES**  
**Division 15—Division of Senior and Disability Services**  
**Chapter 4—Older Americans Act**

**ORDER OF RULEMAKING**

By the authority vested in the Department of Health and Senior Services under section 192.2000, RSMo 2016, the department amends a rule as follows:

19 CSR 15-4.200 is amended.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on March 1, 2022 (47 MoReg 347-348). Those sections with changes are reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: The Department of Health and Senior Services received two (2) comments on the proposed amendment.

COMMENT #1: The Joint Committee on Administrative Rules commented that the reference to 45 CFR Part 75 and 45 CFR Part 200 should be incorporated by reference in section (1).

RESPONSE AND EXPLANATION OF CHANGE: The department reviewed and will incorporate by reference 45 CFR Part 75 and 2 CFR Part 200 in section (1).

COMMENT #2: Staff comment regarding proposed language “in accordance with the area plan preprint instructions” in section (2) is not necessary, as waiver provisions are provided in 19 CSR 15-4.150. RESPONSE AND EXPLANATION OF CHANGE: The department reviewed and is not moving forward with the proposed new language “in accordance with the area plan preprint instructions” and will delete the proposed language from the section (2).

**19 CSR 15-4.200 Area Agency on Aging Subgrants or Contracts**

(1) The area agency on aging shall follow applicable procurement standards as specified in 45 CFR Part 75, which has been incorporated by reference in this rule, as published on October 1, 2021, by the Office of the Federal Register, National Archives and Record Administration, 7G Street NW, Suite A-734, Washington, DC 20401-0001 and available at <https://bookstore.gpo.gov/catalog/code-federal-regulations-cfrs-print>; and 2 CFR Part 200, which has been incorporated by reference in this rule, as published on January 1, 2021, by the Office of the Federal Register, National Archives and Record Administration, 7G Street NW, Suite A-734, Washington, DC 20401-0001 and available at <https://bookstore.gpo.gov/catalog/code-federal-regulations-cfrs-print>. This rule does not incorporate any subsequent amendments or additions.

(2) The area agency on aging shall use subgrants or contracts with service providers to provide supportive services, nutrition services, and/or in-home services under all Older Americans Act (OAA) funding sources. For waiver of this requirement, the area agency on aging shall submit a written request that thoroughly documents that direct provision of service, using its own employees, is necessary—

**Title 19—DEPARTMENT OF HEALTH AND SENIOR SERVICES**  
**Division 15—Division of Senior and Disability Services**  
**Chapter 4—Older Americans Act**

**ORDER OF RULEMAKING**

By the authority vested in the Department of Health and Senior

Services under section 192.2000, RSMo 2016, the department amends a rule as follows:

**19 CSR 15-4.210 Area Agency on Aging Grievance Procedures is amended.**

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on March 1, 2022 (47 MoReg 348-349). No changes have been made in the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

**Title 19—DEPARTMENT OF HEALTH AND SENIOR SERVICES**  
**Division 15—Division of Senior and Disability Services**  
**Chapter 4—Older Americans Act**

**ORDER OF RULEMAKING**

By the authority vested in the Department of Health and Senior Services under section 192.2000, RSMo 2016, the department amends a rule as follows:

**19 CSR 15-4.220 Area Agency on Aging Technical Assistance, Monitoring, and Evaluation Responsibilities is amended.**

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on March 1, 2022 (47 MoReg 349). No changes have been made in the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: The Department of Health and Senior Services received one (1) comment on the proposed amendment.

COMMENT #1: PurFoods, LLC d/b/a Mom’s Meals inquired if “to the extent feasible” may be added to section (3) regarding the monitoring requirement for annual on-site evaluations of service providers.

RESPONSE: An area agency on aging that is unable to comply with a specific requirement shall request a waiver under 19 CSR 15-4.150, which establishes such procedure. No changes have been made to the amendment as a result this comment.

**Title 19—DEPARTMENT OF HEALTH AND SENIOR SERVICES**  
**Division 15—Division of Senior and Disability Services**  
**Chapter 4—Older Americans Act**

**ORDER OF RULEMAKING**

By the authority vested in the Department of Health and Senior Services under section 192.2000, RSMo 2016, the department amends a rule as follows:

**19 CSR 15-4.230 Multipurpose Senior Center is amended.**

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on March 1, 2022 (47 MoReg 349-350). No changes have been made in the text of the proposed amendment, so it is not reprinted here. This proposed

amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

**Title 19—DEPARTMENT OF HEALTH AND SENIOR SERVICES**

**Division 15—Division of Senior and Disability Services  
Chapter 4—Older Americans Act**

**ORDER OF RULEMAKING**

By the authority vested in the Department of Health and Senior Services under section 192.2000, RSMo 2016, the department amends a rule as follows:

**19 CSR 15-4.240 Nutrition Service Requirements is amended.**

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on March 1, 2022 (47 MoReg 350-352). No changes have been made in the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

**Title 19—DEPARTMENT OF HEALTH AND SENIOR SERVICES**

**Division 15—Division of Senior and Disability Services  
Chapter 4—Older Americans Act**

**ORDER OF RULEMAKING**

By the authority vested in the Department of Health and Senior Services under section 192.2000, RSMo 2016, the department amends a rule as follows:

**19 CSR 15-4.245 is amended.**

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on March 1, 2022 (47 MoReg 359-362). Those sections with changes are reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: The Department of Health and Senior Services received eleven (11) comments on the proposed amendment.

COMMENT #1: The Missouri Association of Area Agencies on Aging inquired if subsection (12)(C) and section (13) are included in the proposed amendment.

RESPONSE: The proposed amendment includes subsection (12)(C) and section (13), as published in the *Missouri Register* on March 1, 2022 (47 MoReg 359-362). No changes have been made to the amendment as a result this comment.

COMMENT #2: The Missouri Association of Area Agencies on Aging inquired if the general requirements set forth in 19 CSR 15-7.010, cited within this amendment, are remaining in Chapter 7.

RESPONSE: The general requirements set forth in 19 CSR 15-7.010 will remain in Chapter 7; no changes were made to 19 CSR 15-7.010. No changes have been made to the amendment as a result this comment.

COMMENT #3: The Missouri Association of Area Agencies on Aging inquired if the retention period for records of daily food and equipment may be increased to one (1) year instead of the three (3) years as proposed in subsection (8)(D).

RESPONSE AND EXPLANATION OF CHANGE: The department took into consideration the comment and the requirements of the federal food safety regulation, 21 CFR 117.315, and the retention period required in subsection (8)(D) will be changed to two (2) years.

COMMENT #4: The Missouri Association of Area Agencies on Aging inquired if the annual training requirements in subsection (3)(C) may be clarified and reduced for administrators from sixteen (16) to twelve (12) hours, cook from eight (8) to six (6) hours, cook helper from four (4) to two (2) hours.

RESPONSE: The department believes the training requirements are appropriate and the annual training requirements should not be reduced. No changes have been made to the amendment as a result this comment.

COMMENT #5: The Missouri Association of Area Agencies on Aging commented that removing section (5) "Nutrition Education" decreases the emphasis on being a nutrition program.

RESPONSE: The Older Americans Act provides that nutrition education should be provided based on the needs of meal participants. No changes have been made to the amendment as a result this comment.

COMMENT #6: PurFoods, LLC d/b/a Mom's Meals inquired if "to the extent applicable to their jurisdiction" may be added to section (2).

RESPONSE: The general requirements for all service providers included in 19 CSR 15-7.010 are required by federal and state laws. No changes have been made to the amendment as a result this comment.

COMMENT #7: PurFoods, LLC d/b/a Mom's Meals inquired if "to the extent applicable" may be added to subsection (4)(B) regarding the requirement for meal count reports for meals served.

RESPONSE: Meal counts, including this information, are required for the federal annual report pursuant to federal law. No changes have been made to the amendment as a result this comment.

COMMENT #8: PurFoods, LLC d/b/a Mom's Meals inquired if "or other appropriate menu plan developed by an individual who meets the standards of 19 CSR 15-4.240(12)" may be added to subsection (6)(B) regarding the meal planning requirements.

RESPONSE: An area agency on aging that is unable to comply with a specific requirement shall request a waiver under 19 CSR 15-4.150, which establishes such procedure. No changes have been made to the amendment as a result this comment.

COMMENT #9: PurFoods, LLC d/b/a Mom's Meals inquired if "at centers" may be added after "daily" in the first sentence of subsection (9)(H) regarding the food storage requirements.

RESPONSE: The addition of "at centers" is not needed. No changes have been made to the amendment as a result this comment.

COMMENT #10: PurFoods, LLC d/b/a Mom's Meals inquired if "Except as otherwise required by law, an area agency on aging, with approval of the division, may waive any requirements relating to home-delivered meals service providers." may be added to section (13) regarding requirements for home-delivered meals service providers.

RESPONSE: An area agency on aging that is unable to comply with a specific requirement shall request a waiver under 19 CSR 15-4.150, which establishes such procedure. No changes have been made to the amendment as a result this comment.

COMMENT #11: The Missouri Department of Health and Senior Services commented that the menu plan included in the amendment on page 23 should be removed, subsection (6)(F) that incorporated by reference the menu plan in the rule is removed by the amendment. The amendment removes the reference to the menu plan, as such the menu plan should also be removed from the amendment.

RESPONSE AND EXPLANATION OF CHANGE: The department reviewed the comment and will remove the menu plan included in the amendment on page 23. The amendment removed subsection (6)(F) that incorporated by reference the menu plan. The amendment removed subsection (6)(F) that referenced the menu plan, as such the menu plan on page 23 should also be removed in the amendment.

#### **19 CSR 15-4.245 Nutrition Service Standards**

(8) Requirements for handling prepared foods are as follows:

(D) The proper equipment shall be used to maintain hot foods at or above one hundred forty degrees Fahrenheit (140°F) and cold foods at or below forty-one degrees Fahrenheit (41°F) while serving. Hot and cold food temperatures shall be checked immediately prior to service and recorded daily. Records must be kept for two (2) years at the center;

### **Title 19—DEPARTMENT OF HEALTH AND SENIOR SERVICES**

#### **Division 15—Division of Senior and Disability Services Chapter 4—Older Americans Act**

#### **ORDER OF RULEMAKING**

By the authority vested in the Department of Health and Senior Services under section 192.2000, RSMo 2016, the department amends a rule as follows:

#### **19 CSR 15-4.250 Area Agency on Aging Nutrition Services Incentive Program is amended.**

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on March 1, 2022 (47 MoReg 352-353). No changes have been made in the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

### **Title 19—DEPARTMENT OF HEALTH AND SENIOR SERVICES**

#### **Division 15—Division of Senior and Disability Services Chapter 4—Older Americans Act**

#### **ORDER OF RULEMAKING**

By the authority vested in the Department of Health and Senior Services under section 192.2000, RSMo 2016, the department amends a rule as follows:

#### **19 CSR 15-4.260 Outreach Services is amended.**

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on March 1, 2022 (47 MoReg 353). No changes have been made in the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

### **Title 19—DEPARTMENT OF HEALTH AND SENIOR SERVICES**

#### **Division 15—Division of Senior and Disability Services Chapter 4—Older Americans Act**

#### **ORDER OF RULEMAKING**

By the authority vested in the Department of Health and Senior Services under section 192.2000, RSMo 2016, the department amends a rule as follows:

#### **19 CSR 15-4.270 Legal Assistance is amended.**

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on March 1, 2022 (47 MoReg 353-354). No changes have been made in the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

### **Title 19—DEPARTMENT OF HEALTH AND SENIOR SERVICES**

#### **Division 15—Division of Senior and Disability Services Chapter 4—Older Americans Act**

#### **ORDER OF RULEMAKING**

By the authority vested in the Department of Health and Senior Services under sections 192.2000 and 192.2310, RSMo 2016, the department amends a rule as follows:

#### **19 CSR 15-4.280 Ombudsman Services is amended.**

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on March 1, 2022 (47 MoReg 354). No changes have been made in the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

### **Title 19—DEPARTMENT OF HEALTH AND SENIOR SERVICES**

#### **Division 15—Division of Senior and Disability Services Chapter 4—Older Americans Act**

#### **ORDER OF RULEMAKING**

By the authority vested in the Department of Health and Senior Services under section 192.2000, RSMo 2016, the department amends a rule as follows:

#### **19 CSR 15-4.290 Information and Assistance is amended.**

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on March 1, 2022 (47 MoReg 354). No changes have been made in the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.



SUMMARY OF COMMENTS: No comments were received.

**Title 19—DEPARTMENT OF HEALTH AND SENIOR SERVICES**  
**Division 15—Division of Senior and Disability Services**  
**Chapter 4—Older Americans Act**

**ORDER OF RULEMAKING**

By the authority vested in the Department of Health and Senior Services under section 192.2000, RSMo 2016, the department amends a rule as follows:

**19 CSR 15-4.295 Information and Assistance Service Standards is amended.**

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on March 1, 2022 (47 MoReg 358-359). No changes have been made in the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

**Title 19—DEPARTMENT OF HEALTH AND SENIOR SERVICES**  
**Division 15—Division of Senior and Disability Services**  
**Chapter 4—Older Americans Act**

**ORDER OF RULEMAKING**

By the authority vested in the Department of Health and Senior Services under section 192.2000, RSMo 2016, the department amends a rule as follows:

**19 CSR 15-4.300 Record Keeping and Confidentiality is amended.**

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on March 1, 2022 (47 MoReg 355). No changes have been made in the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

**Title 19—DEPARTMENT OF HEALTH AND SENIOR SERVICES**  
**Division 15—Division of Senior and Disability Services**  
**Chapter 4—Older Americans Act**

**ORDER OF RULEMAKING**

By the authority vested in the Department of Health and Senior Services under section 192.2000, RSMo 2016, the department amends a rule as follows:

**19 CSR 15-4.410 Transportation Service Standards is amended.**

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on March 1, 2022 (47 MoReg 356-358). No changes have been made in the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

**Title 19—DEPARTMENT OF HEALTH AND SENIOR SERVICES**  
**Division 15—Division of Senior and Disability Services**  
**Chapter 4—Older Americans Act**

**ORDER OF RULEMAKING**

By the authority vested in the Department of Health and Senior Services under sections 251.070, 536.023, and 192.2000, RSMo 2016, the department amends a rule as follows:

**19 CSR 15-4.440 Division Formal Hearings is amended.**

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on March 1, 2022 (47 MoReg 355-356). No changes have been made in the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

**Title 19—DEPARTMENT OF HEALTH AND SENIOR SERVICES**  
**Division 15—Division of Senior and Disability Services**  
**Chapter 6—Alternative Services**

**ORDER OF RULEMAKING**

By the authority vested in the Department of Health and Senior Services under sections 251.070 and 536.023, RSMo 2016, the department rescinds a rule as follows:

**19 CSR 15-6.020 Division Mediation Procedures is rescinded.**

A notice of proposed rulemaking containing the proposed rescission was published in the *Missouri Register* on March 1, 2022 (47 MoReg 355). No changes have been made to the proposed rescission, so it is not reprinted here. This proposed rescission becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

**Title 20—DEPARTMENT OF COMMERCE AND INSURANCE**  
**Division 2200—State Board of Nursing**  
**Chapter 2—Minimum Standards for Approved Programs of Professional Nursing**

**ORDER OF RULEMAKING**

By the authority vested in the State Board of Nursing under section 335.036, RSMo Supp. 2021, the board amends a rule as follows:

**20 CSR 2200-2.001 Definitions is amended.**

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on March 15, 2022 (47 MoReg 415-417). No changes have been made in the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

**Title 20—DEPARTMENT OF COMMERCE AND  
INSURANCE  
Division 2200—State Board of Nursing  
Chapter 2—Minimum Standards for Approved  
Programs of Professional Nursing**

**ORDER OF RULEMAKING**

By the authority vested in the State Board of Nursing under section 335.036, RSMo Supp. 2021, the board amends a rule as follows:

**20 CSR 2200-2.010 Approval is amended.**

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on March 15, 2022 (47 MoReg 417-418). No changes have been made in the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

**Title 20—DEPARTMENT OF COMMERCE AND  
INSURANCE  
Division 2200—State Board of Nursing  
Chapter 2—Minimum Standards for Approved  
Programs of Professional Nursing**

**ORDER OF RULEMAKING**

By the authority vested in the State Board of Nursing under section 335.036, RSMo Supp. 2021, the board amends a rule as follows:

**20 CSR 2200-2.030 Change of Sponsorship is amended.**

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on March 15, 2022 (47 MoReg 418-419). No changes have been made in the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

**Title 20—DEPARTMENT OF COMMERCE AND  
INSURANCE  
Division 2200—State Board of Nursing  
Chapter 2—Minimum Standards for Approved  
Programs of Professional Nursing**

**ORDER OF RULEMAKING**

By the authority vested in the State Board of Nursing under section 335.036, RSMo Supp. 2021, the board amends a rule as follows:

**20 CSR 2200-2.035 Multiple Campuses is amended.**

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on March 15, 2022 (47 MoReg 419). No changes have been made in the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

**Title 20—DEPARTMENT OF COMMERCE AND  
INSURANCE  
Division 2200—State Board of Nursing  
Chapter 2—Minimum Standards for Approved  
Programs of Professional Nursing**

**ORDER OF RULEMAKING**

By the authority vested in the State Board of Nursing under section 335.036, RSMo Supp. 2021, the board amends a rule as follows:

**20 CSR 2200-2.040 Program Changes Requiring Board Approval,  
Notification, or Both is amended.**

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on March 15, 2022 (47 MoReg 419). No changes have been made in the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

**Title 20—DEPARTMENT OF COMMERCE AND  
INSURANCE  
Division 2200—State Board of Nursing  
Chapter 2—Minimum Standards for Approved  
Programs of Professional Nursing**

**ORDER OF RULEMAKING**

By the authority vested in the State Board of Nursing under section 335.036, RSMo Supp. 2021, the board amends a rule as follows:

**20 CSR 2200-2.060 Administrator/Faculty is amended.**

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on March 15, 2022 (47 MoReg 420). No changes have been made in the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

**Title 20—DEPARTMENT OF COMMERCE AND  
INSURANCE  
Division 2200—State Board of Nursing  
Chapter 2—Minimum Standards for Approved  
Programs of Professional Nursing**

**ORDER OF RULEMAKING**

By the authority vested in the State Board of Nursing under section 335.036, RSMo Supp. 2021, the board amends a rule as follows:

**20 CSR 2200-2.070 Physical Facilities and Instructional Resources  
is amended.**

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on March 15, 2022 (47 MoReg 420-421). No changes have been made in the text of the proposed amendment, so it is not reprinted here. This proposed

amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

**Title 20—DEPARTMENT OF COMMERCE AND  
INSURANCE  
Division 2200—State Board of Nursing  
Chapter 2—Minimum Standards for Approved  
Programs of Professional Nursing  
ORDER OF RULEMAKING**

By the authority vested in the State Board of Nursing under section 335.036, RSMo Supp. 2021, the board amends a rule as follows:

**20 CSR 2200-2.080 Clinical Experiences is amended.**

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on March 15, 2022 (47 MoReg 421). No changes have been made in the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

**Title 20—DEPARTMENT OF COMMERCE AND  
INSURANCE  
Division 2200—State Board of Nursing  
Chapter 2—Minimum Standards for Approved  
Programs of Professional Nursing  
ORDER OF RULEMAKING**

By the authority vested in the State Board of Nursing under section 335.036, RSMo Supp. 2021, the board amends a rule as follows:

**20 CSR 2200-2.085 Preceptors is amended.**

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on March 15, 2022 (47 MoReg 421). No changes have been made in the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

**Title 20—DEPARTMENT OF COMMERCE AND  
INSURANCE  
Division 2200—State Board of Nursing  
Chapter 2—Minimum Standards for Approved  
Programs of Professional Nursing  
ORDER OF RULEMAKING**

By the authority vested in the State Board of Nursing under section 335.036, RSMo Supp. 2021, the board amends a rule as follows:

**20 CSR 2200-2.100 Educational Program is amended.**

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on March 15, 2022 (47 MoReg 421-422). No changes have been made in the text

of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

**Title 20—DEPARTMENT OF COMMERCE AND  
INSURANCE  
Division 2200—State Board of Nursing  
Chapter 2—Minimum Standards for Approved  
Programs of Professional Nursing  
ORDER OF RULEMAKING**

By the authority vested in the State Board of Nursing under section 335.036, RSMo Supp. 2021, the board amends a rule as follows:

**20 CSR 2200-2.120 Publications is amended.**

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on March 15, 2022 (47 MoReg 422-423). No changes have been made in the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

**Title 20—DEPARTMENT OF COMMERCE AND  
INSURANCE  
Division 2200—State Board of Nursing  
Chapter 2—Minimum Standards for Approved  
Programs of Professional Nursing  
ORDER OF RULEMAKING**

By the authority vested in the State Board of Nursing under section 335.036, RSMo Supp. 2021, the board amends a rule as follows:

**20 CSR 2200-2.130 Program Evaluation is amended.**

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on March 15, 2022 (47 MoReg 423). No changes have been made in the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

**Title 20—DEPARTMENT OF COMMERCE AND  
INSURANCE  
Division 2200—State Board of Nursing  
Chapter 2—Minimum Standards for Approved  
Programs of Professional Nursing  
ORDER OF RULEMAKING**

By the authority vested in the State Board of Nursing under section 335.036, RSMo Supp. 2021, the board amends a rule as follows:

**20 CSR 2200-2.180 Licensure Examination Performance  
is amended.**

A notice of proposed rulemaking containing the text of the proposed

amendment was published in the *Missouri Register* on March 15, 2022 (47 MoReg 423-424). No changes have been made in the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

**Title 20—DEPARTMENT OF COMMERCE AND  
INSURANCE  
Division 2200—State Board of Nursing  
Chapter 3—Minimum Standards for Approved  
Programs of Practical Nursing  
ORDER OF RULEMAKING**

By the authority vested in the State Board of Nursing under section 335.036, RSMo Supp. 2021, the board amends a rule as follows:

**20 CSR 2200-3.001 Definitions is amended.**

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on March 15, 2022 (47 MoReg 424-425). No changes have been made in the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

**Title 20—DEPARTMENT OF COMMERCE AND  
INSURANCE  
Division 2200—State Board of Nursing  
Chapter 3—Minimum Standards for Approved  
Programs of Practical Nursing  
ORDER OF RULEMAKING**

By the authority vested in the State Board of Nursing under section 335.036, RSMo Supp. 2021, the board amends a rule as follows:

**20 CSR 2200-3.010 Approval is amended.**

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on March 15, 2022 (47 MoReg 425-427). No changes have been made in the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

**Title 20—DEPARTMENT OF COMMERCE AND  
INSURANCE  
Division 2200—State Board of Nursing  
Chapter 3—Minimum Standards for Approved  
Programs of Practical Nursing  
ORDER OF RULEMAKING**

By the authority vested in the State Board of Nursing under section 335.036, RSMo Supp. 2021, the board amends a rule as follows:

**20 CSR 2200-3.030 Change in Sponsorship is amended.**

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on March 15, 2022 (47 MoReg 427). No changes have been made in the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

**Title 20—DEPARTMENT OF COMMERCE AND  
INSURANCE  
Division 2200—State Board of Nursing  
Chapter 3—Minimum Standards for Approved  
Programs of Practical Nursing  
ORDER OF RULEMAKING**

By the authority vested in the State Board of Nursing under section 335.036, RSMo Supp. 2021, the board amends a rule as follows:

**20 CSR 2200-3.035 Multiple Campuses is amended.**

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on March 15, 2022 (47 MoReg 427-428). No changes have been made in the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

**Title 20—DEPARTMENT OF COMMERCE AND  
INSURANCE  
Division 2200—State Board of Nursing  
Chapter 3—Minimum Standards for Approved  
Programs of Practical Nursing  
ORDER OF RULEMAKING**

By the authority vested in the State Board of Nursing under section 335.036, RSMo Supp. 2021, the board amends a rule as follows:

**20 CSR 2200-3.040 Program Changes Requiring Board Approval,  
Notification, or Both is amended.**

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on March 15, 2022 (47 MoReg 428). No changes have been made in the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

**Title 20—DEPARTMENT OF COMMERCE AND  
INSURANCE  
Division 2200—State Board of Nursing  
Chapter 3—Minimum Standards for Approved  
Programs of Practical Nursing  
ORDER OF RULEMAKING**

By the authority vested in the State Board of Nursing under section 335.036, RSMo Supp. 2021, the board amends a rule as follows:

**20 CSR 2200-3.060 Administrator/Faculty is amended.**

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on March 15, 2022 (47 MoReg 428-429). No changes have been made in the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

**Title 20—DEPARTMENT OF COMMERCE AND  
INSURANCE  
Division 2200—State Board of Nursing  
Chapter 3—Minimum Standards for Approved  
Programs of Practical Nursing**

**ORDER OF RULEMAKING**

By the authority vested in the State Board of Nursing under section 335.036, RSMo Supp. 2021, the board amends a rule as follows:

**20 CSR 2200-3.070 Physical Facilities and Instructional Resources  
is amended.**

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on March 15, 2022 (47 MoReg 429). No changes have been made in the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

**Title 20—DEPARTMENT OF COMMERCE AND  
INSURANCE  
Division 2200—State Board of Nursing  
Chapter 3—Minimum Standards for Approved  
Programs of Practical Nursing**

**ORDER OF RULEMAKING**

By the authority vested in the State Board of Nursing under section 335.036, RSMo Supp. 2021, the board amends a rule as follows:

**20 CSR 2200-3.080 Clinical Experiences is amended.**

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on March 15, 2022 (47 MoReg 429-430). No changes have been made in the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

**Title 20—DEPARTMENT OF COMMERCE AND  
INSURANCE  
Division 2200—State Board of Nursing  
Chapter 3—Minimum Standards for Approved  
Programs of Practical Nursing**

**ORDER OF RULEMAKING**

By the authority vested in the State Board of Nursing under section 335.036, RSMo Supp. 2021, the board amends a rule as follows:

**20 CSR 2200-3.085 Preceptors is amended.**

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on March 15, 2022 (47 MoReg 430). No changes have been made in the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

**Title 20—DEPARTMENT OF COMMERCE AND  
INSURANCE  
Division 2200—State Board of Nursing  
Chapter 3—Minimum Standards for Approved  
Programs of Practical Nursing**

**ORDER OF RULEMAKING**

By the authority vested in the State Board of Nursing under section 335.036, RSMo Supp. 2021, the board amends a rule as follows:

**20 CSR 2200-3.100 Educational Program is amended.**

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on March 15, 2022 (47 MoReg 430-431). No changes have been made in the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

**Title 20—DEPARTMENT OF COMMERCE AND  
INSURANCE  
Division 2200—State Board of Nursing  
Chapter 3—Minimum Standards for Approved  
Programs of Practical Nursing**

**ORDER OF RULEMAKING**

By the authority vested in the State Board of Nursing under section 335.036, RSMo Supp. 2021, the board amends a rule as follows:

**20 CSR 2200-3.120 Publications is amended.**

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on March 15, 2022 (47 MoReg 431). No changes have been made in the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

**Title 20—DEPARTMENT OF COMMERCE AND  
INSURANCE  
Division 2200—State Board of Nursing  
Chapter 3—Minimum Standards for Approved  
Programs of Practical Nursing**

**ORDER OF RULEMAKING**

By the authority vested in the State Board of Nursing under section 335.036, RSMo Supp. 2021, the board amends a rule as follows:

**20 CSR 2200-3.130 Program Evaluation is amended.**

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on March 15, 2022 (47 MoReg 431-432). No changes have been made in the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

**Title 20—DEPARTMENT OF COMMERCE AND  
INSURANCE  
Division 2200—State Board of Nursing  
Chapter 3—Minimum Standards for Approved  
Programs of Practical Nursing**

**ORDER OF RULEMAKING**

By the authority vested in the State Board of Nursing under section 335.036, RSMo Supp. 2021, the board amends a rule as follows:

**20 CSR 2200-3.180 Licensure Examination Performance  
is amended.**

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on March 15, 2022 (47 MoReg 432-433). No changes have been made in the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

**Title 20—DEPARTMENT OF COMMERCE AND  
INSURANCE  
Division 2200—State Board of Nursing  
Chapter 8—Minimum Standards for Approved  
Veteran's Bridge Programs of Practical Nursing**

**ORDER OF RULEMAKING**

By the authority vested in the State Board of Nursing under section 335.036, RSMo Supp. 2021, the board amends a rule as follows:

**20 CSR 2200-8.001 Definitions is amended.**

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on March 15, 2022 (47 MoReg 433-434). No changes have been made in the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

**Title 20—DEPARTMENT OF COMMERCE AND  
INSURANCE  
Division 2200—State Board of Nursing  
Chapter 8—Minimum Standards for Approved  
Veteran's Bridge Programs of Practical Nursing**

**ORDER OF RULEMAKING**

By the authority vested in the State Board of Nursing under section 335.036, RSMo Supp. 2021, the board amends a rule as follows:

**20 CSR 2200-8.010 Approval is amended.**

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on March 15, 2022 (47 MoReg 434-435). No changes have been made in the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

**Title 20—DEPARTMENT OF COMMERCE AND  
INSURANCE  
Division 2200—State Board of Nursing  
Chapter 8—Minimum Standards for Approved  
Veteran's Bridge Programs of Practical Nursing**

**ORDER OF RULEMAKING**

By the authority vested in the State Board of Nursing under section 335.036, RSMo Supp. 2021, the board amends a rule as follows:

**20 CSR 2200-8.030 Change in Sponsorship is amended.**

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on March 15, 2022 (47 MoReg 435-436). No changes have been made in the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

**Title 20—DEPARTMENT OF COMMERCE AND  
INSURANCE  
Division 2200—State Board of Nursing  
Chapter 8—Minimum Standards for Approved  
Veteran's Bridge Programs of Practical Nursing**

**ORDER OF RULEMAKING**

By the authority vested in the State Board of Nursing under section 335.036, RSMo Supp. 2021, the board amends a rule as follows:

**20 CSR 2200-8.035 Multiple Campuses is amended.**

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on March 15, 2022 (47 MoReg 436). No changes have been made in the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

**Title 20—DEPARTMENT OF COMMERCE AND  
INSURANCE  
Division 2200—State Board of Nursing  
Chapter 8—Minimum Standards for Approved  
Veteran's Bridge Programs of Practical Nursing**

**ORDER OF RULEMAKING**

By the authority vested in the State Board of Nursing under section 335.036, RSMo Supp. 2021, the board amends a rule as follows:

**20 CSR 2200-8.040** Program Changes Requiring Board Approval, Notification, or Both is **amended**.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on March 15, 2022 (47 MoReg 436). No changes have been made in the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

**Title 20—DEPARTMENT OF COMMERCE AND INSURANCE**

**Division 2200—State Board of Nursing  
Chapter 8—Minimum Standards for Approved  
Veteran's Bridge Programs of Practical Nursing**

**ORDER OF RULEMAKING**

By the authority vested in the State Board of Nursing under section 335.036, RSMo Supp. 2021, the board amends a rule as follows:

**20 CSR 2200-8.060** Administrator/Faculty is **amended**.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on March 15, 2022 (47 MoReg 436-437). No changes have been made in the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

**Title 20—DEPARTMENT OF COMMERCE AND INSURANCE**

**Division 2200—State Board of Nursing  
Chapter 8—Minimum Standards for Approved  
Veteran's Bridge Programs of Practical Nursing**

**ORDER OF RULEMAKING**

By the authority vested in the State Board of Nursing under section 335.036, RSMo Supp. 2021, the board amends a rule as follows:

**20 CSR 2200-8.070** Physical Facilities and Instructional Resources is **amended**.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on March 15, 2022 (47 MoReg 437-438). No changes have been made in the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

**Title 20—DEPARTMENT OF COMMERCE AND INSURANCE**

**Division 2200—State Board of Nursing  
Chapter 8—Minimum Standards for Approved  
Veteran's Bridge Programs of Practical Nursing**

**ORDER OF RULEMAKING**

By the authority vested in the State Board of Nursing under section

335.036, RSMo Supp. 2021, the board amends a rule as follows:

**20 CSR 2200-8.080** Clinical Experiences is **amended**.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on March 15, 2022 (47 MoReg 438). No changes have been made in the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

**Title 20—DEPARTMENT OF COMMERCE AND INSURANCE**

**Division 2200—State Board of Nursing  
Chapter 8—Minimum Standards for Approved  
Veteran's Bridge Programs of Practical Nursing**

**ORDER OF RULEMAKING**

By the authority vested in the State Board of Nursing under section 335.036, RSMo Supp. 2021, the board amends a rule as follows:

**20 CSR 2200-8.085** Preceptors is **amended**.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on March 15, 2022 (47 MoReg 438). No changes have been made in the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

**Title 20—DEPARTMENT OF COMMERCE AND INSURANCE**

**Division 2200—State Board of Nursing  
Chapter 8—Minimum Standards for Approved  
Veteran's Bridge Programs of Practical Nursing**

**ORDER OF RULEMAKING**

By the authority vested in the State Board of Nursing under section 335.036, RSMo Supp. 2021, the board amends a rule as follows:

**20 CSR 2200-8.100** Educational Program is **amended**.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on March 15, 2022 (47 MoReg 438-440). No changes have been made in the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

**Title 20—DEPARTMENT OF COMMERCE AND INSURANCE**

**Division 2200—State Board of Nursing  
Chapter 8—Minimum Standards for Approved  
Veteran's Bridge Programs of Practical Nursing**

**ORDER OF RULEMAKING**

By the authority vested in the State Board of Nursing under section

335.036, RSMo Supp. 2021, the board amends a rule as follows:

**20 CSR 2200-8.120 Publications is amended.**

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on March 15, 2022 (47 MoReg 440). No changes have been made in the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

**Title 20—DEPARTMENT OF COMMERCE AND INSURANCE**

**Division 2200—State Board of Nursing  
Chapter 8—Minimum Standards for Approved  
Veteran's Bridge Programs of Practical Nursing**

**ORDER OF RULEMAKING**

By the authority vested in the State Board of Nursing under section 335.036, RSMo Supp. 2021, the board amends a rule as follows:

**20 CSR 2200-8.130 Program Evaluation is amended.**

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on March 15, 2022 (47 MoReg 440-441). No changes have been made in the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

**Title 20—DEPARTMENT OF COMMERCE AND INSURANCE**

**Division 2200—State Board of Nursing  
Chapter 8—Minimum Standards for Approved  
Veteran's Bridge Programs of Practical Nursing**

**ORDER OF RULEMAKING**

By the authority vested in the State Board of Nursing under section 335.036, RSMo Supp. 2021, the board amends a rule as follows:

**20 CSR 2200-8.180 Licensure Examination Performance  
is amended.**

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on March 15, 2022 (47 MoReg 441-442). No changes have been made in the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

**Title 20—DEPARTMENT OF COMMERCE AND INSURANCE**

**Division 2220—State Board of Pharmacy  
Chapter 2—General Rules**

**ORDER OF RULEMAKING**

By the authority vested in the Missouri Board of Pharmacy under

sections 338.240 and 338.280, RSMo 2016, and sections 338.010, 338.140, and 338.210, RSMo Supp. 2021, the board amends a rule as follows:

**20 CSR 2220-2.010 is amended.**

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on March 1, 2022 (47 MoReg 362-371). Those sections with changes are reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: The board received five (5) comments on the amendment from CVS Health, as reflected below.

COMMENT #1: CVS Health filed a comment suggesting the board amend subsection (1)(B) to accommodate or reference pharmacist electronic final product verification that would be authorized by pending board rule 20 CSR 2220-2.011.

RESPONSE: Subsection (1)(B) provides final verification must comply with subsection (1)(B) "except as otherwise provided by law," which was intended to accommodate pending rule 20 CSR 2220-2.011 once finalized and other applicable rule/statutory provisions. No changes have been made in response to the comment, given 20 CSR 2220-2.011 is still pending, as is the referenced qualifying language. However, the board will educate licensees on 20 CSR 2220-2.011 allowances after the rule is finalized.

COMMENT #2: CVS Health filed a comment regarding proposed subsection (1)(A) which would prohibit pharmacies from introducing or enforcing any policies, systems, or practices that jeopardize, inhibit, or threaten patient safety or the safe provisions of pharmacy services. CVS Health primarily suggests the amended language may lead to subjective board enforcement and potential confusion for pharmacy staff. CVS Health suggested amending subsection (1)(A) to instead require policies/procedures for the pharmacist-in-charge (PIC) to communicate patient safety concerns to the permit holder.

RESPONSE: Subsection (1)(A) is an important patient safety measure which would prohibit Missouri pharmacies from introducing or enforcing any policy or practice that could threaten patient safety or place Missouri patients at risk. In regards to the language being overly broad, the board has adopted a standards of practice regulatory approach that is focused on articulating the expected standard of care, in lieu of prescriptive rules that are unduly restrictive/burdensome or may not be applicable to a particular practice setting. Proposed subsection (1)(A) aligns with this approach and establishes a general standard of care for all Missouri pharmacies that will better protect Missouri patients. The board's approach is consistent with the regulation of other healthcare professions and would grant needed regulatory flexibility for both current and future pharmacy practice models. Further, CVS Health's proposed communication policy would not prevent permit holders from establishing systems or practices that could place Missouri patients at risk. As a result, no changes have been made in response to the comment.

COMMENT #3: CVS Health suggested the board amend the provisions of subsection (1)(A) that require a pharmacist to be physically present in a pharmacy to include/reference the statutory allowances for remote dispensing pharmacies.

RESPONSE: The opening provision of section (1) provides subsections (1)(A)–(O) are applicable "except as otherwise provided by law." This exemption language was intended to accommodate current and future statutory/rule allowances, in lieu of listing all allowances/exceptions individually. As a result, no changes have been made in response to the comment. However, the board will educate licensees on other allowances authorized by Missouri law, including allowances for remote dispensing.



COMMENT #4: CVS Health expressed concerns regarding proposed subsection (1)(C), which would require that pharmacies provide “adequate staffing and resources. . .to allow licensees/registrants to safely and accurately provide pharmacy services.” CVS Health suggested the proposed language is overly broad, may be confusing for pharmacy personnel, and could lead to subjective board enforcement. CVS Health further alleges subjective enforcement would not afford pharmacy permit holders proper due process.

RESPONSE: Pharmacists play a critical role in providing patient care and protecting the public health. The board has received a concerning number of complaints from board licensees/registrants alleging pharmacy staffing/resources are insufficient to provide safe patient care. In line with these concerns, the American Pharmacists Association, the National Alliance of State Pharmacy Associations, and the National Association of Boards of Pharmacy recently endorsed a pharmacist’s right “to a working environment where the necessary resources are allocated to provide both legally required patient care services, as well as any additional enhanced patient care services offered.” Subsection (1)(C) would enhance patient protection by ensuring Missouri pharmacies are adequately staffed and resourced. The proposed language aligns with a standards of practice approach (see board response to comment# 2) and would grant pharmacies needed flexibility to tailor staffing/resources to their individual needs, as opposed to the board imposing a uniform requirement/definition that may not be appropriate for all practice settings (e.g., mandatory staffing ratios). In regards to due process, the Missouri Administrative Procedures Act affords licensees/registrants due process protections in the event the board takes official action. As a result, no changes have been made in response to the comment.

COMMENT #5: CVS Health suggested the board amend subsection (3)(C) to allow licensees to produce records within seventy-two (72) business hours of a board request, instead of the proposed two (2) hours. CVS Health suggested many pharmacy records are kept in manual form and additional time may be needed to locate and provide the documentation.

RESPONSE AND EXPLANATION OF CHANGE: The board has amended the rule to address the concerns raised and to be consistent with other board record production requirements.

## 20 CSR 2220-2.010 Pharmacy Standards of Operation

(3) Record Keeping. Pharmacy records must be accurately maintained in compliance with applicable state and federal law. Records required by Chapters 195 and 338, RSMo, or divisions 20 CSR 2220 and 19 CSR 30 shall be available for inspection, photographing, or duplication by a board representative.

(C) Unless otherwise provided by law, records required by Chapter 338 or 20 CSR 2220 that do not have a specified retention time must be kept for two (2) years and readily retrievable at the request of the board or the board’s authorized designee. Records maintained at a pharmacy must be produced immediately or within two (2) hours of a request from the board or the board’s authorized designee, or by making a computer terminal available to the inspector for immediate use to review the records requested. Records not maintained at a pharmacy must be produced within three (3) business days of a board request.

## Title 20—DEPARTMENT OF COMMERCE AND INSURANCE

### Division 2220—State Board of Pharmacy Chapter 2—General Rules

## ORDER OF RULEMAKING

By the authority vested in the Missouri Board of Pharmacy under sections 338.240 and 338.280, RSMo 2016, and sections 338.010

and 338.140, RSMo Supp. 2021, the board adopts a rule as follows:

20 CSR 2220-2.011 is adopted.

A notice of proposed rulemaking containing the text of the proposed rule was published in the *Missouri Register* on March 15, 2022 (47 MoReg 442). Those sections with changes are reprinted here. This proposed rule becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: The board received four (4) comments on the rule as reflected below.

COMMENT #1: Alison Smith filed a comment requesting clarification on whether the rule will prohibit the use of pictures during the sterile compounding process to document proper compounding, if the final preparation is still physically verified by a pharmacist.

RESPONSE: The proposed rule would be applicable to instances where the final product is not physically verified by a pharmacist. The rule would not impact activities identified in the comment if a pharmacist will be physically verifying the final product/preparation. As a result, no changes have been made to the proposed rule.

COMMENT #2: CVS Health filed a comment in support of the rule concept but recommended the rule allow/reference the use of multiple images of the filled prescription/medication order.

RESPONSE AND EXPLANATION OF CHANGE: The rule has been amended as recommended to provide clarity.

COMMENT #3: CVS Health suggested the rule allow pharmacists to use qualifying bar-code scanning technology to verify the final prescription/medication order in lieu of capturing a visual image of the product, if the bar-code scanning technology can associate the label affixed to the container with the imaged product.

RESPONSE: Physical verification of an image of the actual product by a licensed pharmacist would enhance patient protection and help prevent medication errors. Further, additional research and public comment would be needed prior to incorporating the proposed change due to the variances in bar-code scanning technology. Accordingly, no changes have been made in response to the comment at this time; however, the board will monitor rule implementation and consider the suggestion during future rule discussions.

COMMENT #4: TelePharm submitted a comment suggesting the board modify the requirement in section (2) that only a pharmacist may override designated technology generated errors, warnings, alerts, or exceptions. TelePharm suggested the requirement would pose pharmacy workflow challenges and require system upgrades for current pharmacy software/system providers. TelePharm proposed alternative language that would require pharmacists to review and authorize designated overrides performed by a pharmacy technician or intern pharmacist and noted the rule imposes other patient safety safeguards that would ensure public protection.

RESPONSE AND EXPLANATION OF CHANGE: The board agrees and has amended the rule to incorporate the suggestion.

## 20 CSR 2220-2.011 Electronic Final Product Verification (Pharmacists)

(1) Pharmacist Verification. A Missouri licensed pharmacist may use an electronic verification system to verify the accuracy of a final prescription/medication order, provided—

(A) The electronic verification system allows the pharmacist to see an exact, clear, and unobstructed visual image or images of the filled prescription/medication order contents and the label affixed to the container. If multiple units are being dispensed, the pharmacist must be able to see and verify an image or images of each unit and each individual affixed label. A mechanism must be in place to record or communicate the pharmacist’s verification approval;

(2) Technology Requirements. Electronic verification systems must be maintained in good working order and must provide a clear, unobstructed visual image or images of the filled prescription/medication order contents and the affixed label for each individual prescription or medication order. Use of the electronic verification system must be terminated if the system is not properly functioning and the root cause identified and corrected before further use. Prior to dispensing, a pharmacist shall review and authorize overrides performed by a pharmacy technician or intern pharmacist of any technology generated errors, warnings, alerts, or exceptions related to system functioning or medication verification/accuracy. Documentation of the pharmacist's review and authorization must be maintained in the pharmacy's records.

(A) The electronic verification system must be implemented and validated by a pharmacist prior to initial use to confirm proper functioning. The system must be revalidated by a pharmacist in accordance with the pharmacy's policies and procedures.

(B) Proof of compliance with validation/revalidation requirements must be documented and maintained in the pharmacy's records, including but not limited to the identity of the pharmacist performing the required validation/testing and validation/testing date(s) and results.

## **Title 20—DEPARTMENT OF COMMERCE AND INSURANCE**

### **Division 2220—State Board of Pharmacy Chapter 2—General Rules**

#### **ORDER OF RULEMAKING**

By the authority vested in the Missouri Board of Pharmacy under sections 338.240 and 338.280, RSMo 2016, and sections 338.010 and 338.140, RSMo Supp. 2021, the board adopts a rule as follows:

#### **20 CSR 2220-2.012 Technology Assisted Prescription/Medication Order Verification (Intern Pharmacists and Pharmacy Technicians) is adopted.**

A notice of proposed rulemaking containing the text of the proposed rule was published in the *Missouri Register* on March 15, 2022 (47 MoReg 442-444). No changes have been made in the text of the proposed rule, so it is not reprinted here. This proposed rule becomes effective thirty (30) days after publication in the *Code of State Regulations*.

**SUMMARY OF COMMENTS:** The board received four (4) comments on the rule as reflected below.

**COMMENT #1:** CVS Health suggested the rule allow technology-assisted verification (TAV) for all medication, including controlled substances. CVS Health suggested the proposed rule provides sufficient safeguards to protect patients if the allowance is expanded, provided the appropriate policies and procedures are implemented by the pharmacist-in-charge.

**RESPONSE:** In lieu of final verification by a pharmacist, the proposed rule will allow pharmacy technicians and intern pharmacists to perform TAV of non-controlled medication dispensed in the manufacturer's original unopened unit of use package, or non-controlled medication that has been repackaged in compliance with the board's rules and previously verified by a Missouri-licensed pharmacist. Other medications present a higher risk of medication errors due to required human intervention/manipulation and should be verified by a Missouri licensed pharmacist as reflected in the rule. Additionally, pharmacist verification of controlled substances is particularly appropriate given the higher risk of addiction and diversion for controlled substance medication. No changes have been made in response to the comment in the interest of patient safety.

**COMMENT #2:** CVS Health suggested removing the limit on the number of pharmacy technicians or intern pharmacists performing TAV that a pharmacist may simultaneously supervise. CVS Health alternatively recommended the board require the pharmacist-in-charge to "maintain sufficient staffing to ensure TAV is being safely and accurately performed," without additional restrictions.

**RESPONSE:** Additional research and public comment would be appropriate prior to removing the proposed supervision limit to ensure patient protection and adequate pharmacist supervision. Public comment is particularly appropriate from staff pharmacists who may not have direct input on pharmacy staffing/assigned duties. No changes have been made in response to the comment at this time. However, the board will monitor rule implementation/compliance and review supervision limits during future rule discussions.

**COMMENT #3:** CVS Health suggested the board remove the requirement that TAV systems complete one thousand (1,000) consecutive product verifications during the initial validation process, and alternatively suggested allowing the pharmacist-in-charge to select the required sample size.

**RESPONSE:** The proposed one thousand (1,000) consecutive product verifications would better protect Missouri patients by ensuring uniform verification of system competency and reliability prior to initial use. No changes have been made in response to the comment. However, the board will monitor rule implementation/compliance and consider the suggestion during future rule discussions.

**COMMENT #4:** CVS Health alleges requiring pharmacies to notify the board of a dispensing error would violate the privilege/confidentiality protections provided by the Patient Safety and Quality Improvement Act of 2005.

**RESPONSE:** The board disagrees with CVS Health's interpretation of the Patient Safety and Quality Improvement Act of 2005 (PSQI), which does not preempt the state's legislatively judicially recognized authority to regulate the practice of pharmacy. Significantly, CVS Health's argument would essentially shield all pharmacy records from board review if separately reported to a qualifying Patient Safety Organization (PSO). This interpretation places patients at risk and may lead to fraud and abuse. Additionally, the PSQI expressly provides patient safety work product does not include information that is collected, maintained, or developed separately, or exists separately, from a patient safety evaluation system [see 42 U.S.C. section 299b-21(7)]. The PSQI further provides, "such separate information or a copy thereof reported to a patient safety organization shall not by reason of its reporting be considered patient safety work product." Moreover, supplementary comments to the final PSQI rule provide, "The Patient Safety Act does not affect any State law requiring a provider to report information that is not patient safety work product. The fact that information is collected, developed, or analyzed under the protections of the Patient Safety Act does not shield a provider from needing to undertake similar activities, if applicable, outside the ambit of the statute, so that the provider can meet its obligations with non-patient safety work product. The Patient Safety Act, while precluding other organizations and entities from requiring providers to provide them with patient safety work product, recognizes that the original records underlying patient safety work product remain available in most instances for the providers to meet these other reporting requirements." No changes have been made in response to the comment.

## **Title 20—DEPARTMENT OF COMMERCE AND INSURANCE**

### **Division 2220—State Board of Pharmacy Chapter 2—General Rules**

#### **ORDER OF RULEMAKING**

By the authority vested in the Missouri Board of Pharmacy under

sections 338.240 and 338.280, RSMo 2016, and sections 338.010, 338.140, and 338.210, RSMo Supp. 2021, the board amends a rule as follows:

**20 CSR 2220-2.090 Pharmacist-in-Charge is amended.**

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on March 1, 2022 (47 MoReg 372-374). No changes have been made in the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

**SUMMARY OF COMMENTS:** The board received three (3) comments on the amendment from two (2) entities, as reflected below.

**COMMENT #1:** Walgreen Co. filed a comment suggesting the board amend subsection (1)(A) which would require permit holders to consult with the pharmacist-in-charge (PIC) prior to modifying or expanding pharmacy services and provide the PIC an opportunity to give input. Walgreens suggested the requirement would lead to “unintended consequences by creating a barrier to open and honest dialogue” between pharmacy management and the PIC.

**RESPONSE:** Under Missouri law, the PIC is personally responsible for pharmacy compliance in conjunction with the permit holder, and can be individually disciplined for pharmacy violations. Inclusion of the PIC in pharmacy operational decisions that will impact the delivery of pharmacy services is appropriate and will better ensure patient safety. This collaboration is particularly appropriate given the PIC is responsible for, and aware of, daily pharmacy operations and capabilities. Additionally, the rule adopts a flexible approach that would allow permit holders to determine the appropriate mode, manner, and extent of PIC consultation for their individual practice setting. Significantly, subsection (1)(A) includes an exception for emergency/urgent situations, which should alleviate the concerns raised. As a result, no changes have been made in response to the comment.

**COMMENT #2:** CVS Health filed a comment suggesting the board amend subsection (1)(B), which requires that permit holders provide the PIC “designated time” to review compliance activities. CVS Health indicated “designated time” is undefined, which could lead to subjective board enforcement, confusion by pharmacy personnel, and interruptions in patient care. CVS Health suggested deleting the “designated time” requirement in its entirety.

**RESPONSE:** Under Missouri law, the PIC is personally responsible for pharmacy compliance in conjunction with the permit holder, and can be individually disciplined for pharmacy violations. The board believes designated time for the PIC to review pharmacy compliance while not engaged in answering phones, counseling patients, administering vaccines, and performing clinical services, is vitally important to ensuring patient safety. Significantly, the rule incorporates a flexible approach that would allow Missouri pharmacies to determine the appropriate time, scope, and manner of PIC review for their individual practice setting. In regards to defining terms, Missouri courts have held statutory/regulatory terms should be defined in accordance with their plain and ordinary meaning, which would be applicable in this case. As a result, no changes have been made in response to the comment.

**COMMENT #3:** CVS Health filed a comment regarding proposed subsection (1)(C), which provides PICs must have authority to temporarily suspend or restrict pharmacy operations if deemed reasonably necessary or appropriate to ensure the safe provision of pharmacy services or to ensure pharmacy compliance, pending final direction or approval from the permit holder. CVS Health alleges this grant of authority could interfere with patient care and suggested the rule instead require a mechanism for communication between the PIC and the permit holder.

**RESPONSE:** The PIC, in conjunction with the permit holder, is personally responsible for pharmacy compliance and ensuring patient safety, and can be individually disciplined for pharmacy violations. To ensure patient safety, PICs should have authority to temporarily suspend pharmacy operations in the event of a threat to patient safety or pharmacy compliance, pending final direction from the permit holder. Notably, the rule does not prohibit permit holders from establishing the communication measures suggested by CVS Health. Further, the PIC’s authority would be temporary until the permit holder is able to provide final direction or approval of the temporary suspension/modification. Prompt response and action by permit holders would prevent the interruptions in patient care identified by CVS Health. Accordingly, no change has been made in response to the comment.

**Title 20—DEPARTMENT OF COMMERCE AND  
INSURANCE  
Division 2220—State Board of Pharmacy  
Chapter 2—General Rules**

**ORDER OF RULEMAKING**

By the authority vested in the Missouri Board of Pharmacy under sections 338.240 and 338.280, RSMo 2016, and sections 338.010 and 338.140, RSMo Supp. 2021, the board amends a rule as follows:

**20 CSR 2220-2.200 Sterile Compounding is amended.**

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on March 15, 2022 (47 MoReg 444). No changes have been made in the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

**SUMMARY OF COMMENTS:** The board received one (1) comment on the amendment as reflected below.

**COMMENT #1:** Alison Smith filed a comment suggesting the board amend the rule to allow portability of aseptic skill technique skill assessments between pharmacies under common ownership that are compounding similar risk levels using similar compounding rooms/equipment. Ms. Smith suggested the amendment would increase patient access to compounding services, particularly for affiliated pharmacies that may need to quickly move staff between facilities.

**RESPONSE:** The board received similar public comments during the rule drafting process. The *United States Pharmacopeia* (USP) is in the process of revising USP Chapter 797 which establishes nationally recognized sterile compounding standards. Public comments on the draft USP revisions are scheduled to close on March 17, 2022. The board anticipates substantially revising 20 CSR 2220-2.200 after USP Chapter 797 is revised to align with national standards, including national standards for portability of technique assessments. No changes have been made in response to the comment at this time. However, the board will review the public comment and portability of technique assessments after USP Chapter 797 is finalized.

**T**his section may contain notice of hearings, correction notices, public information notices, rule action notices, statements of actual costs, and other items required to be published in the *Missouri Register* by law.

**Title 22—MISSOURI CONSOLIDATED HEALTH  
CARE PLAN  
Division 10—Health Care Plan  
Chapter 2—State Membership**

**IN ADDITION**

**22 CSR 10-2.075 Review and Appeals Procedure**

The Missouri Consolidated Health Care Plan (MCHCP) requests that a typographical error be corrected in subpart (3)(B)2.B.(V)(a) of this rule. The 800 area code should have been submitted and published as 888. MCHCP requests that the Administrative Rules Division of the Office of the Secretary of State correct this typographical error. The text for subpart (3)(B)2.B.(V)(a) will read as follows:

(a) First and second level preservice, first and second level post-service, and concurrent claim appeals must be submitted in writing to—

Anthem Blue Cross and Blue Shield  
Attn: Grievance Department  
PO Box 105568  
Atlanta, Georgia 30348-5568  
or by fax to (888) 859-3046

This correction will appear in the July 31, 2022, update to the *Code of State Regulations*.

**Title 22—MISSOURI CONSOLIDATED HEALTH  
CARE PLAN  
Division 10—Health Care Plan  
Chapter 3—Public Entity Membership**

**IN ADDITION**

**22 CSR 10-3.075 Review and Appeals Procedure**

The Missouri Consolidated Health Care Plan requests that a typographical error be corrected in subpart (3)(B)2.B.(V)(a) of this rule. The 800 area code should have been submitted and published as 888. MCHCP requests that the Administrative Rules Division of the Office of the Secretary of State correct this typographical error. The text for subpart (3)(B)2.B.(V)(a) will read as follows:

(a) First and second level preservice, first and second level post-service, and concurrent claim appeals must be submitted in writing to—

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Attn: Grievance Department  
PO Box 105568  
Atlanta, Georgia 30348-5568  
or by fax to (888) 859-3046

This correction will appear in the July 31, 2022, update to the *Code of State Regulations*.

**T**he Secretary of State is required by sections 347.141 and 359.481, RSMo, to publish dissolutions of limited liability companies and limited partnerships. The content requirements for the one-time publishing of these notices are prescribed by statute. This listing is published pursuant to these statutes. We request that documents submitted for publication in this section be submitted in camera ready 8 1/2" x 11" manuscript by email to [adrules.dissolutions@sos.mo.gov](mailto:adrules.dissolutions@sos.mo.gov).

**NOTICE OF WINDING UP FOR LIMITED LIABILITY COMPANY  
TO ALL CREDITORS OF AND CLAIMANTS AGAINST  
ADVANTAGE TITLE & ABSTRACT LLC**

On April 25, 2022, ADVANTAGE TITLE & ABSTRACT LLC, a Missouri Limited Liability Company (the "Company"), filed a Notice of Winding Up for Limited Liability Company with the Missouri Secretary of State, effective as of April 25, 2022.

All persons with claims against the Company may submit any claim in accordance with this notice to: Alisha J. Pitts, 11180 E 1350 Rd, Stockton, MO 65785. All claims must include the name, address, and telephone number of the claimant; the amount claimed; the basis for the claim; the documentation of the claim; and the date(s) of the event(s) on which the claim is based occurred.

All claims against the Company will be barred unless a proceeding to enforce the claim is commenced within three years after the publication of this notice.

**NOTICE OF WINDING UP  
TO ALL CREDITORS OF AND CLAIMANTS AGAINST  
PROVENCE HOMES, INC.**

On March 31, 2022, Provence Homes, Inc. filed its Notice of Winding Up for Provence Homes, Inc. with the Missouri Secretary of State. Provence Homes, Inc. requests that all persons and organizations who have claims against it present them immediately by letter to John Lober at 3700 NW 100<sup>th</sup> Street, Kansas City, MO 64154.

All claims must include the following information: (a) name and address of the claimant, (b) the amount claimed, (c) date on which the claim arose, (d) basis for the claim and documentation thereof, and (e) whether or not the claim was secured and, if so, the collateral used as security.

All claims against Provence Homes, Inc. will be barred unless a proceeding to enforce the claim is commenced within two (2) years after the date of publication of this notice.

**NOTICE OF WINDING UP OF LIMITED LIABILITY COMPANY TO ALL  
CREDITORS OF AND CLAIMANTS AGAINST MOUND CITY CONSTRUCTION,  
LLC.**

On May 30, 2022, Mound City Construction, LLC, filed its Notice of Winding Up with the Missouri Secretary of State.

Claims against the corporation must be submitted to Gerardo Vega, 939 Holly Hills Ave., Apt. 2E, Saint Louis, MO 63111.

Claims must contain: 1) claimant name, address, and telephone number; 2) the amount claimed; 3) the date on which the claim arose; & 4) a brief description of the basis of the claim, including supporting documentation.

All claims against Mound City Construction, LLC will be barred unless proceedings to enforce the claim are commenced within three (3) years of the date of this notice's publication.

**NOTICE OF DISSOLUTION TO ALL CREDITORS OF AND CLAIMANTS  
AGAINST TRI-COM, INC.**

Tri-Com, Inc., a Missouri Corporation, filed voluntary Articles of Dissolution with the Missouri Secretary of State on April 27, 2022. Any and all claims against Tri-Com, Inc. may be sent to Checkett, Pauly, Bay & Morgan, LLC. Attn: Sarah, P.O. Box 409, Carthage, Missouri 64836. Each such claim should include the following: The name, address and telephone number of the claimant; amount of the claim; the basis of the claim; and any and all pertinent documents supporting the claim.

NOTICE: Any and all claims against Tri-Com, Inc. will be barred unless a proceeding to enforce the claim is commenced within two years after the date of publication of this notice.

**NOTICE OF WINDING UP  
TO ALL CREDITORS OF AND CLAIMANTS AGAINST  
GARDEN VALLEY MANOR & REHAB, LLC**

On June 3, 2022, Garden Valley Manor & Rehab, LLC, filed its Notice of Winding Up for Limited Liability Company with the Missouri Secretary of State. Garden Valley Manor & Rehab, LLC, requests that all persons and organizations who have claims against it present them immediately by letter to Garden Valley Manor & Rehab, LLC, 111 Old Orchard Rd, Bonne Terre MO 63628.

All claims must include the following information: (a) name and address of the claimant, (b) the amount claimed, (c) date on which the claim arose, (d) basis for the claim and documentation thereof, and (e) whether or not the claim was secured and, if so, the collateral used as security.

All claims against Garden Valley Manor & Rehab, LLC, will be barred unless a proceeding to enforce the claim is commenced within three (3) years after the date of publication of this notice.

**NOTICE TO UNKNOWN CREDITORS OF  
MOFFET AVENUE MACHINE SHOP, LLC**

Moffet Avenue Machine Shop, LLC (the "Company") has been dissolved pursuant to Section 347.137 of the Missouri Limited Liability Company Act by filing Articles of Termination with the Missouri Secretary of State on June 7, 2022. Pursuant to Section 347.141 of the Missouri Limited Liability Company Act, any claims against the Company must be sent to:

Eric Graham  
4900 Main Street, Suite 900  
Kansas City, MO 64112

Claims submitted must include the following information: (1) claimant name, address and phone number; (2) name of debtor; (3) account or other number by which the debtor may identify the claimant; (4) a brief description of the nature of the debt or the basis of the claim; (5) the amount of the claim; (6) the date the claim was incurred; and (7) supporting documentation for the claim, if any.

**NOTICE: A CLAIM AGAINST THE LIMITED LIABILITY COMPANY WILL BE BARRED UNLESS A PROCEEDING TO ENFORCE THE CLAIM IS COMMENCED WITHIN THREE (3) YEARS AFTER THE PUBLICATION OF THIS NOTICE.**

Please confirm receipt of this publication request. Please contact me at the email or telephone number listed below if you have any questions regarding this publication.

**NOTICE OF WINDING UP  
TO ALL CREDITORS OF AND CLAIMANTS AGAINST  
ST. FRANCOIS MANOR RESIDENTIAL CARE I, LLC**

On June 3, 2022, St. Francois Manor Residential Care I, LLC, filed its Notice of Winding Up for Limited Liability Company with the Missouri Secretary of State. St. Francois Manor Residential Care I, LLC, requests that all persons and organizations who have claims against it present them immediately by letter to St. Francois Manor Residential Care I, LLC, 111 Old Orchard Rd, Bonne Terre MO 63628.

All claims must include the following information: (a) name and address of the claimant, (b) the amount claimed, (c) date on which the claim arose, (d) basis for the claim and documentation thereof, and (e) whether or not the claim was secured and, if so, the collateral used as security.

All claims against St. Francois Manor Residential Care I, LLC, will be barred unless a proceeding to enforce the claim is commenced within three (3) years after the date of publication of this notice.

**NOTICE OF WINDING UP  
TO ALL CREDITORS OF AND CLAIMANTS AGAINST  
WHITE OAK MANOR, LLC**

On June 3, 2022, White Oak Manor, LLC, filed its Notice of Winding Up for Limited Liability Company with the Missouri Secretary of State. White Oak Manor, LLC, requests that all persons and organizations who have claims against it present them immediately by letter to White Oak Manor, LLC, 111 Old Orchard Rd, Bonne Terre MO 63628.

All claims must include the following information: (a) name and address of the claimant, (b) the amount claimed, (c) date on which the claim arose, (d) basis for the claim and documentation thereof, and (e) whether or not the claim was secured and, if so, the collateral used as security.

All claims against White Oak Manor, LLC, will be barred unless a proceeding to enforce the claim is commenced within three (3) years after the date of publication of this notice.

On May 25, 2022, Seasons Entertainment Group, LLC ("LLC"), a Missouri limited liability company, filed its Notice of Winding Up for Limited Liability Company with the Missouri Secretary of State, Charter # LCo760698. All claims against LLC should be submitted in writing by mail to the LLC in care of Elizabeth Jones, 10 Willowyck Ct, St Louis, MO 63141. Claims must include name and address of claimant; amount claimed; date claim arose; brief description of basis of claim; and documentation of claim. Deadline for receipt of claim by LLC is 90 calendar days from date of this notice. All claims against LLC will be barred unless a proceeding to enforce the claim is commenced within three years after publication of this notice.

**NOTICE TO CREDITORS AND CLAIMANTS OF  
KANSAS CITY SOCIAL INVESTMENT POOL, LLC**

KANSAS CITY SOCIAL INVESTMENT POOL, LLC, a Missouri limited liability company (the "Company"), has dissolved and is in the process of winding up its affairs.

On May 19, 2022, the Company filed a Notice of Winding Up with the Missouri Secretary of State pursuant to RSMo. Section 347.137.

All claims against the Company should be presented in accordance with this notice. Claims should be in writing and sent to the Company at this mailing address:

Alicia M. Johnson  
4001 Blue Parkway, Suite 300  
Kansas City, MO 64130

The claim must contain: (1) the name, address and telephone number of the claimants; (2) the amount of the claim or other relief demanded; (3) the basis of the claim and any documents related to the claim; and (4) the date(s) as of which the event(s) on which the claim is based occurred. Any and all claims against the Company will be barred unless a proceeding to enforce the claim is commenced within three years after publication of this notice.

**NOTICE OF DISSOLUTION TO ALL CREDITORS  
AND CLAIMANTS AGAINST MARKO'S DISTRIBUTING, INC.**

On June 3, 2022, Marko's Distributing, Inc. filed its Articles of Dissolution with the Missouri Secretary of State. The dissolution was effective on May 24, 2022.

YOU ARE HEREBY NOTIFIED that if you believe you have a claim against Marko's Distributing, Inc., you must submit a summary in writing of the circumstances surrounding your claim to the said Marko's Distributing, Inc. at the following address: Marko's Distributing, Inc., C/O Robert Cowherd, Attorney at Law, P.O. Box 228, Chillicothe, MO 64601. Telephone: 660-646-0627.

The summary of your claim must include the following information:

1. The name, address and telephone number of the claimant.
2. The amount of the claim.
3. The date on which the event on which the claim is based occurred.
4. A brief description of the nature of the debt or the basis for the claim.

All claims against Marko's Distributing, Inc. will be barred unless the proceeding to enforce the claim is commenced within two (2) years after the publication of this notice.



**NOTICE OF DISSOLUTION TO ALL CREDITORS OF AND CLAIMANTS AGAINST  
MARSHALL LANDS, INC.**

NOTICE IS HEREBY GIVEN that **Marshall Lands, Inc.**, a Missouri corporation (hereinafter the "Corporation") filed its Articles of Dissolution with the Missouri Secretary of State on February 8, 2022.

You are hereby notified that if you believe you have a claim against the Corporation, you must submit the details of your claim in writing to Marshall Lands, Inc., c/o James Marshall, P.O. Box 3, Charleston, Missouri 63834-8102, which shall include the following information: the name, address and phone number of the claimant; the amount claimed; the date on which the claim arose; the basis for the claim; and any documentation for the claim.

All claims against the Corporation will be barred unless a proceeding to enforce the claim is commenced within two (2) years after the publication of this Notice.

**NOTICE OF WINDING UP TO ALL CREDITORS OF AND CLAIMANTS AGAINST  
LUCKY 7 PARTNERSHIP**

NOTICE IS HEREBY GIVEN that **Lucky 7 Partnership**, a Missouri Partnership (hereinafter the "Partnership") is dissolving and winding up its affairs.

You are hereby notified that if you believe you have a claim against the Partnership, you must submit the details of your claim in writing to Lucky 7 Partnership c/o James Marshall, P.O. Box 3, Charleston, Missouri 63834-8102, which shall include the following information: the name, address and phone number of the claimant; the amount claimed; the date on which the claim arose; the basis for the claim; and any documentation for the claim.

All claims against the Partnership will be barred unless a proceeding to enforce the claim is commenced within three (3) years after the publication of this Notice.

**Rule Changes Since Update to  
Code of State Regulations**

This cumulative table gives you the latest status of rules. It contains citations of rulemakings adopted or proposed after deadline for the monthly Update Service to the *Code of State Regulations*. Citations are to volume and page number in the *Missouri Register*, except for material in this issue. The first number in the table cite refers to the volume number or the publication year—46 (2021) and 47 (2022). MoReg refers to *Missouri Register* and the numbers refer to a specific *Register* page, R indicates a rescission, W indicates a withdrawal, S indicates a statement of actual cost, T indicates an order terminating a rule, N.A. indicates not applicable, RAN indicates a rule action notice, RUC indicates a rule under consideration, and F indicates future effective date.

Rule Number	Agency	Emergency	Proposed	Order	In Addition
<b>OFFICE OF ADMINISTRATION</b>					
1 CSR 10	State Officials' Salary Compensation Schedule				45 MoReg 1926
1 CSR 20-5.020	Personnel Advisory Board and Division of Personnel		47 MoReg 225	This Issue	
1 CSR 40-1.050	Purchasing and Materials Management		47 MoReg 549		
<b>DEPARTMENT OF AGRICULTURE</b>					
2 CSR 30-10.010	Animal Health	47 MoReg 221	47 MoReg 231	47 MoReg 837	
2 CSR 60-4.110	Grain Inspection and Warehousing		47 MoReg 823		
2 CSR 60-5.100	Grain Inspection and Warehousing		47 MoReg 824		
2 CSR 80-2.190	State Milk Board		This Issue		
2 CSR 80-5.010	State Milk Board		This Issue		
2 CSR 90-60.020	Weights, Measures and Consumer Protection		47 MoReg 231	47 MoReg 786	
2 CSR 90-60.030	Weights, Measures and Consumer Protection		47 MoReg 231	47 MoReg 786	
2 CSR 90-61.010	Weights, Measures and Consumer Protection		47 MoReg 232	47 MoReg 786	
2 CSR 90-63.010	Weights, Measures and Consumer Protection		47 MoReg 232	47 MoReg 786	
2 CSR 90-63.020	Weights, Measures and Consumer Protection		47 MoReg 233	47 MoReg 787	
2 CSR 90-64.010	Weights, Measures and Consumer Protection		47 MoReg 235	47 MoReg 787	
<b>DEPARTMENT OF CONSERVATION</b>					
3 CSR 10-7.433	Conservation Commission			47 MoReg 837	
			47 MoReg 871		
3 CSR 10-7.435	Conservation Commission			47 MoReg 895	
3 CSR 10-7.437	Conservation Commission			47 MoReg 895	
3 CSR 10-7.600	Conservation Commission			47 MoReg 896	
3 CSR 10-7.705	Conservation Commission		47 MoReg 871		
3 CSR 10-12.109	Conservation Commission		47 MoReg 475	47 MoReg 896	
3 CSR 10-12.110	Conservation Commission		47 MoReg 475	47 MoReg 896	
3 CSR 10-12.115	Conservation Commission		47 MoReg 476	47 MoReg 896	
3 CSR 10-12.125	Conservation Commission		47 MoReg 477	47 MoReg 896	
3 CSR 10-12.135	Conservation Commission		47 MoReg 478	47 MoReg 897	
3 CSR 10-12.140	Conservation Commission		47 MoReg 478	47 MoReg 897	
3 CSR 10-12.145	Conservation Commission		47 MoReg 482	47 MoReg 897	
<b>DEPARTMENT OF ELEMENTARY AND SECONDARY EDUCATION</b>					
5 CSR 20-100.130	Division of Learning Services		47 MoReg 412		
5 CSR 20-100.140	Division of Learning Services		47 MoReg 413R		
5 CSR 20-100.210	Division of Learning Services		47 MoReg 550		
5 CSR 20-500.250	Division of Learning Services		47 MoReg 780		
5 CSR 30-4.030	Division of Financial and Administrative Services		47 MoReg 872		
5 CSR 30-660.090	Division of Financial and Administrative Services	47 MoReg 779	47 MoReg 784		
<b>DEPARTMENT OF HIGHER EDUCATION AND WORKFORCE DEVELOPMENT</b>					
6 CSR 10-2.190	Commissioner of Higher Education	47 MoReg 473			
6 CSR 10-12.010	Commissioner of Higher Education		47 MoReg 623		
6 CSR 10-13.010	Commissioner of Higher Education		47 MoReg 626		
<b>MISSOURI DEPARTMENT OF TRANSPORTATION</b>					
7 CSR 10-1.010	Missouri Highways and Transportation Commission		47 MoReg 551		
7 CSR 10-1.020	Missouri Highways and Transportation Commission		This Issue		
7 CSR 10-11.020	Missouri Highways and Transportation Commission		47 MoReg 554		
7 CSR 10-25.010	Missouri Highways and Transportation Commission		This Issue		
7 CSR 10-25.030	Missouri Highways and Transportation Commission		This Issue		
7 CSR 10-25.070	Missouri Highways and Transportation Commission		This Issue		
7 CSR 10-25.071	Missouri Highways and Transportation Commission		This Issue		
7 CSR 10-25.080	Missouri Highways and Transportation Commission		This Issue		
7 CSR 10-25.090	Missouri Highways and Transportation Commission		This Issue		
7 CSR 60-2.010	Highway Safety and Traffic Division		47 MoReg 824		
7 CSR 60-2.020	Highway Safety and Traffic Division		47 MoReg 826		
7 CSR 60-2.030	Highway Safety and Traffic Division		47 MoReg 826		
7 CSR 60-2.040	Highway Safety and Traffic Division		47 MoReg 827		
7 CSR 60-2.050	Highway Safety and Traffic Division		47 MoReg 827		
7 CSR 60-2.060	Highway Safety and Traffic Division		47 MoReg 828		
7 CSR 60-3.010	Highway Safety and Traffic Division		47 MoReg 828R		
			47 MoReg 828		
7 CSR 265-10.017	Motor Carrier and Railroad Safety		This Issue		
7 CSR 265-10.025	Motor Carrier and Railroad Safety		This Issue		
7 CSR 265-10.035	Motor Carrier and Railroad Safety		This Issue		
<b>DEPARTMENT OF LABOR AND INDUSTRIAL RELATIONS</b>					
8 CSR 20-2.010	Labor and Industrial Relations Commission		47 MoReg 413	This Issue	
8 CSR 20-3.030	Labor and Industrial Relations Commission		47 MoReg 414	This Issue	
8 CSR 40-1.010	State Board of Mediation		47 MoReg 482		
8 CSR 40-2.010	State Board of Mediation		47 MoReg 483		
8 CSR 40-2.020	State Board of Mediation		47 MoReg 483R		
8 CSR 40-2.025	State Board of Mediation		47 MoReg 483		
8 CSR 40-2.030	State Board of Mediation		47 MoReg 484		
8 CSR 40-2.040	State Board of Mediation		47 MoReg 484R		
8 CSR 40-2.050	State Board of Mediation		47 MoReg 485R		
8 CSR 40-2.055	State Board of Mediation		47 MoReg 485R		

Rule Number	Agency	Emergency	Proposed	Order	In Addition
8 CSR 40-2.060	State Board of Mediation		47 MoReg 485R		
8 CSR 40-2.070	State Board of Mediation		47 MoReg 485		
8 CSR 40-2.080	State Board of Mediation		47 MoReg 486		
8 CSR 40-2.090	State Board of Mediation		47 MoReg 486		
8 CSR 40-2.100	State Board of Mediation		47 MoReg 486		
8 CSR 40-2.120	State Board of Mediation		47 MoReg 487		
8 CSR 40-2.130	State Board of Mediation		47 MoReg 487		
8 CSR 40-2.140	State Board of Mediation		47 MoReg 487		
8 CSR 40-2.150	State Board of Mediation		47 MoReg 489		
8 CSR 40-2.160	State Board of Mediation		47 MoReg 489		
8 CSR 40-2.170	State Board of Mediation		47 MoReg 490		
8 CSR 40-2.180	State Board of Mediation		47 MoReg 490		
8 CSR 50-5.007	Division of Workers' Compensation		47 MoReg 119	47 MoReg 897W	
<b>DEPARTMENT OF MENTAL HEALTH</b>					
9 CSR 10-5.206	Director, Department of Mental Health		47 MoReg 555		
9 CSR 10-5.220	Director, Department of Mental Health		47 MoReg 561		
9 CSR 30-4.005	Certification Standards		47 MoReg 562		
9 CSR 30-4.035	Certification Standards		47 MoReg 562		
9 CSR 30-4.043	Certification Standards		47 MoReg 565		
9 CSR 30-4.0431	Certification Standards		47 MoReg 568		
9 CSR 30-4.0432	Certification Standards		47 MoReg 569		
9 CSR 30-4.045	Certification Standards		47 MoReg 571		
9 CSR 30-4.046	Certification Standards		47 MoReg 573		
9 CSR 30-4.190	Certification Standards		47 MoReg 574		
<b>DEPARTMENT OF NATURAL RESOURCES</b>					
10 CSR 10-5.490	Air Conservation Commission		46 MoReg 2249	47 MoReg 787	
10 CSR 10-6.062	Air Conservation Commission		46 MoReg 2260	47 MoReg 788	
10 CSR 10-6.210	Air Conservation Commission		47 MoReg 235		
10 CSR 10-6.310	Air Conservation Commission		46 MoReg 2263	47 MoReg 788	
10 CSR 140-4.010	Division of Energy				47 MoReg 899
<b>DEPARTMENT OF PUBLIC SAFETY</b>					
11 CSR	Notice of Periodic Rule Review				47 MoReg 900
11 CSR 45-1.090	Missouri Gaming Commission		47 MoReg 491		
11 CSR 45-5.184	Missouri Gaming Commission		47 MoReg 306		
11 CSR 45-5.190	Missouri Gaming Commission		47 MoReg 493		
11 CSR 45-5.210	Missouri Gaming Commission		47 MoReg 493		
11 CSR 45-5.215	Missouri Gaming Commission		47 MoReg 494		
11 CSR 45-5.225	Missouri Gaming Commission		47 MoReg 495		
11 CSR 45-5.265	Missouri Gaming Commission		47 MoReg 307		
11 CSR 45-9.104	Missouri Gaming Commission		47 MoReg 307		
11 CSR 45-9.108	Missouri Gaming Commission		47 MoReg 496		
11 CSR 45-9.118	Missouri Gaming Commission		47 MoReg 496		
11 CSR 45-9.119	Missouri Gaming Commission		47 MoReg 497		
11 CSR 45-9.121	Missouri Gaming Commission		47 MoReg 500		
11 CSR 50-2.080	Missouri State Highway Patrol		47 MoReg 626		
11 CSR 50-2.150	Missouri State Highway Patrol		47 MoReg 627		
11 CSR 50-2.170	Missouri State Highway Patrol		47 MoReg 627		
11 CSR 50-2.320	Missouri State Highway Patrol		47 MoReg 628		
11 CSR 70-2.010	Division of Alcohol and Tobacco Control		47 MoReg 310	This Issue	
11 CSR 70-2.020	Division of Alcohol and Tobacco Control		47 MoReg 311	This Issue	
11 CSR 70-2.030	Division of Alcohol and Tobacco Control		47 MoReg 312	This Issue	
11 CSR 70-2.050	Division of Alcohol and Tobacco Control		47 MoReg 313	This Issue	
11 CSR 70-2.060	Division of Alcohol and Tobacco Control		47 MoReg 314	This Issue	
11 CSR 70-2.070	Division of Alcohol and Tobacco Control		47 MoReg 315	This Issue	
11 CSR 70-2.080	Division of Alcohol and Tobacco Control		47 MoReg 315	This Issue	
11 CSR 70-2.090	Division of Alcohol and Tobacco Control		47 MoReg 316	This Issue	
11 CSR 70-2.100	Division of Alcohol and Tobacco Control		47 MoReg 317	This Issue	
11 CSR 70-2.120	Division of Alcohol and Tobacco Control		47 MoReg 874		
11 CSR 70-2.130	Division of Alcohol and Tobacco Control		47 MoReg 875		
11 CSR 70-2.140	Division of Alcohol and Tobacco Control		47 MoReg 877		
11 CSR 70-2.150	Division of Alcohol and Tobacco Control		47 MoReg 879		
11 CSR 70-2.190	Division of Alcohol and Tobacco Control		47 MoReg 879		
11 CSR 70-2.280	Division of Alcohol and Tobacco Control		47 MoReg 881		
11 CSR 90-2.010	Missouri 911 Service Board	46 MoReg 1713	46 MoReg 1759 47 MoReg 236	47 MoReg 789	
<b>DEPARTMENT OF REVENUE</b>					
12 CSR	Notice of Periodic Rule Review				47 MoReg 900
12 CSR 10-1.020	Director of Revenue		47 MoReg 317	47 MoReg 897	
12 CSR 10-26.231	Director of Revenue		47 MoReg 318	47 MoReg 898	
<b>DEPARTMENT OF SOCIAL SERVICES</b>					
13 CSR	Notice of Periodic Rule Review				47 MoReg 900
13 CSR 65-2.020	Missouri Medicaid and Audit Compliance	47 MoReg 543	47 MoReg 574		
13 CSR 70-3.120	MO HealthNet Division		46 MoReg 1675 47 MoReg 237	47 MoReg 789	
13 CSR 70-3.180	MO HealthNet Division		46 MoReg 1675 47 MoReg 237		
13 CSR 70-3.320	MO HealthNet Division		47 MoReg 883		
13 CSR 70-3.330	MO HealthNet Division		47 MoReg 22	47 MoReg 789	
13 CSR 70-4.051	MO HealthNet Division		47 MoReg 886R		
13 CSR 70-4.100	MO HealthNet Division		46 MoReg 1676 47 MoReg 238	47 MoReg 791	
13 CSR 70-4.110	MO HealthNet Division		46 MoReg 1677 47 MoReg 238	47 MoReg 791	
13 CSR 70-4.120	MO HealthNet Division		46 MoReg 1678 47 MoReg 240	47 MoReg 791	
13 CSR 70-5.010	MO HealthNet Division		47 MoReg 886		
13 CSR 70-15.010	MO HealthNet Division	This Issue	This Issue		
13 CSR 70-15.015	MO HealthNet Division	This Issue	This Issue		

Rule Number	Agency	Emergency	Proposed	Order	In Addition
13 CSR 70-15.020	MO HealthNet Division		46 MoReg 1679 47 MoReg 241	47 MoReg 837 47 MoReg 791	
13 CSR 70-15.030	MO HealthNet Division		47 MoReg 241	47 MoReg 791	
13 CSR 70-15.110	MO HealthNet Division	This Issue	This Issue		
13 CSR 70-15.160	MO HealthNet Division	This Issue	This Issue		
13 CSR 70-15.230	MO HealthNet Division	This Issue	This Issue		
13 CSR 70-65.010	MO HealthNet Division		46 MoReg 1685 47 MoReg 242	47 MoReg 792	
<b>DEPARTMENT OF CORRECTIONS</b>					
14 CSR	Notice of Periodic Rule Review				47 MoReg 900
<b>ELECTED OFFICIALS</b>					
15 CSR 30-14.010	Secretary of State		47 MoReg 886		
15 CSR 50-5.010	Treasurer	47 MoReg 731	47 MoReg 318	47 MoReg 838	
15 CSR 50-5.020	Treasurer	47 MoReg 731	47 MoReg 318	47 MoReg 838	
15 CSR 50-5.030	Treasurer	47 MoReg 735	47 MoReg 322	47 MoReg 841	
15 CSR 50-5.040	Treasurer	47 MoReg 738	47 MoReg 325	47 MoReg 842	
15 CSR 50-5.050	Treasurer	47 MoReg 742	47 MoReg 328	47 MoReg 844	
<b>RETIREMENT SYSTEMS</b>					
16 CSR 10-5.020	The Public School Retirement System of Missouri		47 MoReg 829		
16 CSR 10-6.070	The Public School Retirement System of Missouri		47 MoReg 832		
<b>PUBLIC DEFENDER COMMISSION</b>					
18 CSR 10-3.010	Office of State Public Defender		47 MoReg 123	47 MoReg 792	
<b>DEPARTMENT OF HEALTH AND SENIOR SERVICES</b>					
19 CSR 15-4.010	Division of Senior and Disability Services		47 MoReg 331	This Issue	
19 CSR 15-4.020	Division of Senior and Disability Services		47 MoReg 334	This Issue	
19 CSR 15-4.040	Division of Senior and Disability Services		47 MoReg 335	This Issue	
19 CSR 15-4.050	Division of Senior and Disability Services		47 MoReg 335	This Issue	
19 CSR 15-4.060	Division of Senior and Disability Services		47 MoReg 337	This Issue	
19 CSR 15-4.070	Division of Senior and Disability Services		47 MoReg 337	This Issue	
19 CSR 15-4.080	Division of Senior and Disability Services		47 MoReg 338	This Issue	
19 CSR 15-4.090	Division of Senior and Disability Services		47 MoReg 338	This Issue	
19 CSR 15-4.100	Division of Senior and Disability Services		47 MoReg 339	This Issue	
19 CSR 15-4.105	Division of Senior and Disability Services		47 MoReg 339	This Issue	
19 CSR 15-4.110	Division of Senior and Disability Services		47 MoReg 340	This Issue	
19 CSR 15-4.120	Division of Senior and Disability Services		47 MoReg 340	This Issue	
19 CSR 15-4.130	Division of Senior and Disability Services		47 MoReg 341	This Issue	
19 CSR 15-4.135	Division of Senior and Disability Services		47 MoReg 341	This Issue	
19 CSR 15-4.140	Division of Senior and Disability Services		47 MoReg 341	This Issue	
19 CSR 15-4.150	Division of Senior and Disability Services		47 MoReg 342	This Issue	
19 CSR 15-4.160	Division of Senior and Disability Services		47 MoReg 342	This Issue	
19 CSR 15-4.170	Division of Senior and Disability Services		47 MoReg 343	This Issue	
19 CSR 15-4.175	Division of Senior and Disability Services		47 MoReg 344	This Issue	
19 CSR 15-4.180	Division of Senior and Disability Services		47 MoReg 346	This Issue	
19 CSR 15-4.190	Division of Senior and Disability Services		47 MoReg 346	This Issue	
19 CSR 15-4.200	Division of Senior and Disability Services		47 MoReg 347	This Issue	
19 CSR 15-4.210	Division of Senior and Disability Services		47 MoReg 348	This Issue	
19 CSR 15-4.220	Division of Senior and Disability Services		47 MoReg 349	This Issue	
19 CSR 15-4.230	Division of Senior and Disability Services		47 MoReg 349	This Issue	
19 CSR 15-4.240	Division of Senior and Disability Services		47 MoReg 350	This Issue	
19 CSR 15-4.245	Division of Senior and Disability Services <i>formerly 19 CSR 15-7.060</i>		47 MoReg 359	This Issue	
19 CSR 15-4.250	Division of Senior and Disability Services		47 MoReg 352	This Issue	
19 CSR 15-4.260	Division of Senior and Disability Services		47 MoReg 353	This Issue	
19 CSR 15-4.270	Division of Senior and Disability Services		47 MoReg 353	This Issue	
19 CSR 15-4.280	Division of Senior and Disability Services		47 MoReg 354	This Issue	
19 CSR 15-4.290	Division of Senior and Disability Services		47 MoReg 354	This Issue	
19 CSR 15-4.295	Division of Senior and Disability Services <i>formerly 19 CSR 15-7.050</i>		47 MoReg 358	This Issue	
19 CSR 15-4.300	Division of Senior and Disability Services		47 MoReg 355	This Issue	
19 CSR 15-4.410	Division of Senior and Disability Services <i>formerly 19 CSR 15-7.040</i>		47 MoReg 356	This Issue	
19 CSR 15-4.440	Division of Senior and Disability Services <i>formerly 19 CSR 15-6.025</i>		47 MoReg 355	This Issue	
19 CSR 15-6.020	Division of Senior and Disability Services		47 MoReg 355R	This Issue	
19 CSR 15-6.025	Division of Senior and Disability Services <i>moved to 19 CSR 15-4.440</i>		47 MoReg 355		
19 CSR 15-7.040	Division of Senior and Disability Services <i>moved to 19 CSR 15-4.410</i>		47 MoReg 356		
19 CSR 15-7.050	Division of Senior and Disability Services <i>moved to 19 CSR 15-4.295</i>		47 MoReg 358		
19 CSR 15-7.060	Division of Senior and Disability Services <i>moved to 19 CSR 15-4.245</i>		47 MoReg 359		
19 CSR 20-20.020	Division of Community and Public Health	47 MoReg 115 47 MoReg 621T	47 MoReg 124		
19 CSR 60-50	Missouri Health Facilities Review Committee				
<b>DEPARTMENT OF COMMERCE AND INSURANCE</b>					
20 CSR	Applied Behavior Analysis Maximum Benefit				47 MoReg 385
20 CSR	Construction Claims Binding Arbitration Cap				47 MoReg 43
20 CSR	Non-Economic Damages in Medical Malpractice Cap				47 MoReg 385
20 CSR	Sovereign Immunity Limits				47 MoReg 43
20 CSR	State Legal Expense Fund Cap				47 MoReg 43
20 CSR 2010-5.070	Missouri State Board of Accountancy		47 MoReg 500		
20 CSR 2010-5.080	Missouri State Board of Accountancy		47 MoReg 500		
20 CSR 2010-5.090	Missouri State Board of Accountancy		47 MoReg 501R		
20 CSR 2010-5.100	Missouri State Board of Accountancy		47 MoReg 501		
20 CSR 2010-5.110	Missouri State Board of Accountancy		47 MoReg 502		
20 CSR 2030-16.020	Missouri Board for Architects, Professional Engineers, Professional Land Surveyors, and Professional Landscape Architects		47 MoReg 242	47 MoReg 795	

Rule Number	Agency	Emergency	Proposed	Order	In Addition
20 CSR 2030-16.030	Missouri Board for Architects, Professional Engineers, Professional Land Surveyors, and Professional Landscape Architects		47 MoReg 243	47 MoReg 795	
20 CSR 2030-19.010	Missouri Board for Architects, Professional Engineers, Professional Land Surveyors, and Professional Landscape Architects		47 MoReg 243	47 MoReg 795	
20 CSR 2030-19.020	Missouri Board for Architects, Professional Engineers, Professional Land Surveyors, and Professional Landscape Architects		47 MoReg 244	47 MoReg 795	
20 CSR 2030-20.010	Missouri Board for Architects, Professional Engineers, Professional Land Surveyors, and Professional Landscape Architects		47 MoReg 246	47 MoReg 795	
20 CSR 2085-3.010	Board of Cosmetology and Barber Examiners		47 MoReg 630		
20 CSR 2110-2.050	Missouri Dental Board		47 MoReg 887		
20 CSR 2110-2.120	Missouri Dental Board		47 MoReg 580		
20 CSR 2110-2.240	Missouri Dental Board		47 MoReg 503		
20 CSR 2110-4.020	Missouri Dental Board		47 MoReg 503		
20 CSR 2145-1.040	Missouri Board of Geologist Registration		47 MoReg 784		
20 CSR 2150-5.100	State Board of Registration for the Healing Arts	47 MoReg 621			
20 CSR 2165-2.010	Board of Examiners for Hearing Instrument Specialists		47 MoReg 887		
20 CSR 2165-2.025	Board of Examiners for Hearing Instrument Specialists		47 MoReg 888		
20 CSR 2165-2.040	Board of Examiners for Hearing Instrument Specialists		47 MoReg 889R		
20 CSR 2165-2.060	Board of Examiners for Hearing Instrument Specialists		47 MoReg 889		
20 CSR 2200-2.001	State Board of Nursing		47 MoReg 415	This Issue	
20 CSR 2200-2.010	State Board of Nursing		47 MoReg 417	This Issue	
20 CSR 2200-2.030	State Board of Nursing		47 MoReg 418	This Issue	
20 CSR 2200-2.035	State Board of Nursing		47 MoReg 419	This Issue	
20 CSR 2200-2.040	State Board of Nursing		47 MoReg 419	This Issue	
20 CSR 2200-2.060	State Board of Nursing		47 MoReg 420	This Issue	
20 CSR 2200-2.070	State Board of Nursing		47 MoReg 420	This Issue	
20 CSR 2200-2.080	State Board of Nursing		47 MoReg 421	This Issue	
20 CSR 2200-2.085	State Board of Nursing		47 MoReg 421	This Issue	
20 CSR 2200-2.100	State Board of Nursing		47 MoReg 421	This Issue	
20 CSR 2200-2.120	State Board of Nursing		47 MoReg 422	This Issue	
20 CSR 2200-2.130	State Board of Nursing		47 MoReg 423	This Issue	
20 CSR 2200-2.180	State Board of Nursing		47 MoReg 423	This Issue	
20 CSR 2200-3.001	State Board of Nursing		47 MoReg 424	This Issue	
20 CSR 2200-3.010	State Board of Nursing		47 MoReg 425	This Issue	
20 CSR 2200-3.030	State Board of Nursing		47 MoReg 427	This Issue	
20 CSR 2200-3.035	State Board of Nursing		47 MoReg 427	This Issue	
20 CSR 2200-3.040	State Board of Nursing		47 MoReg 428	This Issue	
20 CSR 2200-3.060	State Board of Nursing		47 MoReg 428	This Issue	
20 CSR 2200-3.070	State Board of Nursing		47 MoReg 429	This Issue	
20 CSR 2200-3.080	State Board of Nursing		47 MoReg 429	This Issue	
20 CSR 2200-3.085	State Board of Nursing		47 MoReg 430	This Issue	
20 CSR 2200-3.100	State Board of Nursing		47 MoReg 430	This Issue	
20 CSR 2200-3.120	State Board of Nursing		47 MoReg 431	This Issue	
20 CSR 2200-3.130	State Board of Nursing		47 MoReg 431	This Issue	
20 CSR 2200-3.180	State Board of Nursing		47 MoReg 432	This Issue	
20 CSR 2200-4.200	State Board of Nursing	47 MoReg 622			
20 CSR 2200-8.001	State Board of Nursing		47 MoReg 433	This Issue	
20 CSR 2200-8.010	State Board of Nursing		47 MoReg 434	This Issue	
20 CSR 2200-8.030	State Board of Nursing		47 MoReg 435	This Issue	
20 CSR 2200-8.035	State Board of Nursing		47 MoReg 436	This Issue	
20 CSR 2200-8.040	State Board of Nursing		47 MoReg 436	This Issue	
20 CSR 2200-8.060	State Board of Nursing		47 MoReg 436	This Issue	
20 CSR 2200-8.070	State Board of Nursing		47 MoReg 437	This Issue	
20 CSR 2200-8.080	State Board of Nursing		47 MoReg 438	This Issue	
20 CSR 2200-8.085	State Board of Nursing		47 MoReg 438	This Issue	
20 CSR 2200-8.100	State Board of Nursing		47 MoReg 438	This Issue	
20 CSR 2200-8.120	State Board of Nursing		47 MoReg 440	This Issue	
20 CSR 2200-8.130	State Board of Nursing		47 MoReg 440	This Issue	
20 CSR 2200-8.180	State Board of Nursing		47 MoReg 441	This Issue	
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20 CSR 2263-2.030	State Committee for Social Workers		47 MoReg 375	47 MoReg 898	
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22 CSR 10-2.075	Health Care Plan				This Issue
22 CSR 10-3.075	Health Care Plan				This Issue

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<b>Animal Health</b>			
2 CSR 30-10.010	Inspection of Meat and Poultry . . . . .	47 MoReg 221 . . . . .	Jan. 26, 2022 . . . . . July 24, 2022
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<b>Divisional of Financial and Administrative Services</b>			
5 CSR 30-660.090	Charter School Local Education Agency (LEA) Attendance Hour Reporting . . . . .	47 MoReg 779 . . . . .	May 3, 2022 . . . . . Feb. 9, 2023
<b>Department of Higher Education and Workforce Development</b>			
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6 CSR 10-2.190	A+ Scholarship Program . . . . .	47 MoReg 473 . . . . .	March 3, 2022 . . . . . Aug. 29, 2022
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<b>Missouri Medicaid Audit and Compliance</b>			
13 CSR 65-2.020	Provider Enrollment and Application . . . . .	47 MoReg 543 . . . . .	March 30, 2022 . . . . . Sept. 26, 2022
<b>MO HealthNet Division</b>			
13 CSR 70-15.010	Inpatient Hospital Services Reimbursement Methodology . . . . .	This Issue . . . . .	July 1, 2022 . . . . . Feb. 23, 2023
13 CSR 70-15.015	Direct Medicaid Payments . . . . .	This Issue . . . . .	July 1, 2022 . . . . . Feb. 23, 2023
13 CSR 70-15.110	Federal Reimbursement Allowance (FRA) . . . . .	This Issue . . . . .	July 1, 2022 . . . . . Feb. 23, 2023
13 CSR 70-15.160	Outpatient Hospital Services Reimbursement Methodology . . . . .	This Issue . . . . .	July 1, 2022 . . . . . Feb. 23, 2023
13 CSR 70-15.190	Out-of-State Hospital Services Reimbursement Plan . . . . .	Next Issue . . . . .	July 1, 2022 . . . . . Feb. 23, 2023
13 CSR 70-15.220	Disproportionate Share Hospital (DSH) Payments . . . . .	Next Issue . . . . .	July 1, 2022 . . . . . Feb. 23, 2023
13 CSR 70-15.230	Upper Payment Limit (UPL) Payment Methodology . . . . .	This Issue . . . . .	July 1, 2022 . . . . . Feb. 23, 2023
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15 CSR 50-5.010	General Organization . . . . .	47 MoReg 731 . . . . .	April 25, 2022 . . . . . July 30, 2022
15 CSR 50-5.020	Missouri Empowerment Scholarship Accounts Program . . . . .	47 MoReg 731 . . . . .	April 25, 2022 . . . . . July 30, 2022
15 CSR 50-5.030	Tax Credit Program . . . . .	47 MoReg 735 . . . . .	April 25, 2022 . . . . . July 30, 2022
15 CSR 50-5.040	Audits and Reporting Requirements . . . . .	47 MoReg 738 . . . . .	April 25, 2022 . . . . . July 30, 2022
15 CSR 50-5.050	Educational Assistance Organizations . . . . .	47 MoReg 742 . . . . .	April 25, 2022 . . . . . July 30, 2022
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20 CSR 2150-5.100	Collaborative Practice Arrangement with Nurses . . . . .	47 MoReg 621 . . . . .	April 11, 2022 . . . . . Oct. 7, 2022
<b>State Board of Nursing</b>			
20 CSR 2200-4.200	Collaborative Practice . . . . .	47 MoReg 622 . . . . .	April 11, 2022 . . . . . Oct. 7, 2022
<b>State Board of Pharmacy</b>			
20 CSR 2220-2.200	Sterile Compounding . . . . .	47 MoReg 409 . . . . .	Feb. 24, 2022 . . . . . Aug. 22, 2022
20 CSR 2220-2.400	Compounding Standards of Practice . . . . .	This Issue . . . . .	June 21, 2022 . . . . . Dec. 17, 2022

# Executive Orders

Executive Orders	Subject Matter	Filed Date	Publication
<b><u>2022</u></b>			
<b>Proclamation</b>	In accordance with <i>Dobbs</i> , Section 188.017, RSMo is hereby effective as of the date of this order	June 24, 2022	Next Issue
<b>22-03</b>	Terminates the State of Emergency declared in Executive Order 22-02.	February 7, 2022	47 MoReg 411
<b>22-02</b>	Declares a State of Emergency and directs the Missouri State Emergency Operations Plan be activated due to forecasted severe winter storm systems.	February 1, 2022	47 MoReg 304
<b>22-01</b>	Establishes and Designates the Missouri Early Childhood State Advisory Council.	January 7, 2022	47 MoReg 222
<b><u>2021</u></b>			
<b>21-13</b>	Creates and establishes the Missouri Supply Chain Task Force.	November 22, 2021	47 MoReg 12
<b>21-12</b>	Designates members of his staff to have supervisory authority over departments, divisions and agencies of state government.	November 5, 2021	46 MoReg 2325
<b>21-11</b>	Orders state offices to be closed on Friday, November 26, 2021.	November 2, 2021	46 MoReg 2241
<b>21-10</b>	Orders steps to oppose federal COVID-19 vaccine mandates within all agencies, boards, commissions, and other entities within the executive branch of state government.	October 28, 2021	46 MoReg 2239
<b>21-09</b>	Terminates the state of emergency declared in Executive Order 20-02, declares a state of emergency, suspends certain regulations related to telemedicine and physical presence for executing documents, and allows state agencies to waive some regulatory requirements.	August 27, 2021	46 MoReg 1727
<b>21-08</b>	Designates members of his staff to have supervisory authority over departments, divisions and agencies of state government	August 10, 2021	46 MoReg 1673
<b>Proclamation</b>	Convenes the First Extra Session of the First Regular Session of the One Hundred and First General Assembly for extending the Federal Reimbursement Allowances (FRA) and related allowances, taxes, and assessments necessary for funding MO HealthNet	June 22, 2021	46 MoReg 1447
<b>21-07</b>	Extends Executive Order 20-02, Executive Order 20-04, Executive Order 20-05, Executive Order 20-06, and Executive Order 20-14 until August 31, 2021	March 26, 2021	46 MoReg 750
<b>21-06</b>	Creates and establishes the Show Me Strong Recovery Task Force and rescinds Executive Order	March 22, 2021	46 MoReg 748
<b>21-05</b>	Designates members of his staff to have supervisory authority over departments, divisions and agencies of state government	February 24, 2021	46 MoReg 605
<b>21-04</b>	Extends Executive Order 21-03 until February 28, 2021 and terminates Executive Order 20-17.	February 19, 2021	46 MoReg 603
<b>21-03</b>	Declares a State of Emergency and exempts hours of service requirements for vehicles transporting residential heating fuel until February 21, 2021	February 11, 2021	46 MoReg 495
<b>21-02</b>	Establishes the Office of Childhood within the Department of Elementary and Secondary Education	January 28, 2021	46 MoReg 394
<b>21-01</b>	Terminates Executive Orders 03-11 and 02-05, and modifies provisions of Executive Order 05-06	January 7, 2021	46 MoReg 314

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## **Administrative Rules Contact Information**

### **General Inquiries**

(573) 751-4015  
rules@sos.mo.gov

### **Curtis W. Treat, Editor-in-Chief**

(573) 751-2022  
curtis.treat@sos.mo.gov

### **Stephanie Martin, Managing Editor**

(573) 522-2196  
stephanie.martin@sos.mo.gov

### **Jacqueline D. White, Publication Specialist II**

(573) 526-1259  
jacqueline.white@sos.mo.gov

### **Vonne Kilbourn, Editor II**

(573) 751-1818  
vonne.kilbourn@sos.mo.gov

### **Jennifer Alex Moore, Editor**

(573) 522-2593  
jennifer.moore@sos.mo.gov

### **Tammy Winkelman, Administrative Aide III**

(573) 751-4015  
tammy.winkelman@sos.mo.gov